

STATE OF WEST VIRGINIA
COMBINED MEDICAL POWER OF ATTORNEY AND LIVING WILL
The Person I Want to Make Health Care Decisions for Me When I Can't Make
Them for Myself and the Kind of Medical Treatment I Want and Don't Want
If I Have a Terminal Condition

Dated: _____, 20____.

I, _____, hereby appoint as my representative to act on my behalf to give, withhold, or withdraw informed consent to health care decisions in the event that I am unable to do so myself.

The person I choose as my representative is:

(Insert the name, address, area code, and telephone number of the person you wish to designate as your representative. Please insert only one name.)

If my representative is unable, unwilling, or disqualified to serve, then I appoint as my successor representative:

(Insert the name, address, area code, and telephone number of the person you wish to designate as your successor representative. Please insert only one name.)

This appointment shall extend to, but not be limited to, health care decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse, or withdraw any and all medical treatment or diagnostic procedures, or autopsy if my representative determines that I, if able to do so, would consent to, refuse, or withdraw such treatment or procedures. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions, subject to the special directives and limitations as stated below:

1. IN A TERMINAL CONDITION: If I am very sick and unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, I direct that life-prolonging intervention that would serve solely to prolong the dying process be withheld or withdrawn. Thus, if a physician has determined that I am in a terminal condition, I understand that completing this form would mean that I refuse cardiopulmonary resuscitation (CPR). It also means that I refuse or request the removal of a breathing machine (ventilator), dialysis, and medically

administered food and fluids, such as might be provided intravenously or by feeding tube. I want to be allowed to die naturally and only be given medications or other medical procedures necessary to keep me comfortable. I want to receive as much medication as is necessary to alleviate my pain. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

2. OTHER LIVING WILL SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER (Comments about mental health treatment, funeral arrangements, autopsy, and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.):

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated in this advance directive.

3. NOT IN A TERMINAL CONDITION: Medical Power of Attorney Special Directives or Limitations on this Power (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, mental health treatment, funeral arrangements, autopsy and organ donation may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.):

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician, and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD, OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

