

STATE OF WEST VIRGINIA
LIVING WILL
The Kind of Medical Treatment I Want and Don't Want
If I Have a Terminal Condition

THIS LIVING WILL made this ____ day of _____, 20__.

I, _____, being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and unable to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging intervention, it is my desire that my dying may not be prolonged under the following circumstances:

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I direct that life-prolonging intervention that would serve solely to prolong the dying process be withheld or withdrawn. I understand that by signing this document I am agreeing to the REMOVAL or REFUSAL of cardiopulmonary resuscitation (CPR), 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.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS (Comments about funeral arrangements, autopsy, mental health treatment, 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.): _____

It is my intention that this living will be honored as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences resulting from such refusal.

I understand the full import of this living will.

Signature of Principal

Address of Principal:

I did not sign the principal's signature above for or at the direction of the principal. I am at least 18 years of age and am not related to the principal by blood or marriage, nor entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, nor directly financially responsible for principal's medical care. I am not the principal's attending physician or the principal's medical power of attorney representative or successor medical power of attorney representative under a medical power of attorney.

Witness

DATE

Witness

DATE

STATE OF _____

COUNTY OF _____

I, _____, a Notary Public of said County, do certify that _____, as principal, and _____ and _____, as witnesses, whose names are signed to the writing above bearing date on the ____ day of _____, 20 __, have this day acknowledged the same before me.

Given under my hand this ____ day of _____, 20 ____.

My commission expires: _____

Notary Public