

**STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY
The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself**

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. This authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions.

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.

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

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 I want or refuse certain treatments.):

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

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

W. Va. Code §16-30-4(h) (2022 S.B. 470)