DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For

West Virginia Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

West Virginia Residents

Statutory Compliant
Advance Directive for
Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For West Virginia Residents

________________________________ ________________________________

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The West Virginia legislature has provided statutes guiding the construction of both a Living Will and a Medical Power of Attorney for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid.

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless

you direct otherwise, this directive will only be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

LIVING WILL DECLARATION

and Personal Instructions

(Pursuant to W.Va Code. Ch.16., Art.30: §16-30-1 to §16-30-25)

1. INTRODUCTION: *The West Virginia Living Will was designed to assist those wishing to refuse life-sustaining treatment in terminal or permanently unconscious condition (§16-30-2(m)). A **terminal condition** is defined as, "an incurable or irreversible condition...for which the administration of life-prolonging intervention will serve only to prolong the dying process"(§16-30-3(aa)). A **permanently unconscious** condition is referred to as a "persistent vegetative state," which is defined as "an irreversible state...in which the person has intact brain-stem function but no higher cortical function and has neither self-awareness or awareness of the surroundings in a learned manner"(§16-30-3(s)).*

   ***Life-sustaining treatment** is defined as, "any medical procedure or intervention that, when applied to a person, would serve to artificially prolong the dying process or to maintain the person in a persistent vegetative state"(§16-30-2(m)). It is specifically noted that such treatment does not include "the administration of medication or the performance of any other medical procedure considered necessary to provide comfort or to alleviate pain"(§16-30-2(m)).*

   The living will may include other specific directions not inconsistent with other provisions of this article. Should any of these directions be held to be invalid, such invalidity shall not affect other directions of the living will which can be given effect without the invalid direction and to this end the directions in the living will are severable.

STATE OF WEST VIRGINIA
LIVING WILL

2. Living will made this __________day of _____________________________, 20________.

3. I,____, being of sound mind, willfully and voluntarily declare that I want my wishes to be respected if I am very sick and not able to communicate my wishes for myself.

4. In the absence of my ability to give directions regarding the use of life-prolonging medical intervention, it is my desire that my dying shall not be prolonged under the following circumstances: (*initial to authorize*)

   A. _____ If I am very sick and not able to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition or to be in a persistent vegetative state (I am unconscious and am neither aware of my environment nor able to interact with others), I direct that life-prolonging medical intervention that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn. 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.

   AND/OR,

   B. I give the following SPECIAL DIRECTIVES OR LIMITATIONS:
   (*Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis and mental health treatment may be placed here. My failure to provide special directives or limitations does not mean that I either want or refuse certain treatments*.) ____
   ____
   ____
   ____
   ____

5. 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.

   (*Sign only in the presence of two qualified witnesses and a notary public*)

6. Signed: ____

   Date: ____

   Address: ____

Statement of Witnesses

7. I did not sign the principal's signature above for or at the direction of the principal. I am at least eighteen years of age and am not related to the principal by blood or marriage, entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, or 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 (*sign in the presence of two witnesses; you and your witnesses must also acknowledge your signatures before a notary*).

8. Witness: ____

Printed Name: ____

Address: ____

9. Witness: ____

Printed Name: ____

Address: ____

REQUIRED CERTIFICATE OF NOTARY PUBLIC
10. State of WEST VIRGINIA,

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_______.

Date my commission expires:____________________________ SEAL:

____
Signature of Notary Public

SECTION II:

MEDICAL POWER OF ATTORNEY

for Health Care and Related Decisions and Acts

(Pursuant to W.Va Statutes, Chapter 16, Article 30: §16-30-1 to §16-30-25)

11. INTRODUCTION. *This section lets you name a person (called an "representative" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. A medical power of attorney may, but need not, be in the following form, and may include other specific directions not inconsistent with other provisions of this article. Should any directions be held invalid, such invalidity shall not affect the other directions of the medical power of attorney which can be given effect without the invalid direction. To this end the directions in the medical power of attorney are severable. If you have questions, seek further counsel and advice.*

STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY

12. Medical Power of Attorney made this _______day of _____________________, 20______.

13. ***Be it known that I***,
    Full Legal Name: ____
    Date of Birth: ____
    Street Address: ____
    City: _______________________________ County: ___________________________
    State: ______________________________ Zip Code: _________________________

    ~~ hereby appoint a representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am not able to do so myself.

14. *The person I choose as my representative is*:
    Name of Representative: ____
    Address: ____
    Telephone: Home:_____________________ Work:______________________
    Cell Phone or Pager: ___________________ E-mail: ____________________

15. *The person I choose as my successor representative is*:
    If my representative is unable, unwilling or disqualified to serve, then I appoint:
    Name of Successor: ____
    Address: ____
    Telephone: Home:_____________________ Work:______________________
    Cell Phone or Pager: ___________________ E-mail: ____________________

16. *Representative and Successor Authorities*. 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.

17. *Intent and Purpose*. 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.

18. *Validation Statement*. 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.

19. *Special Directives or Limitations*: I am giving the following SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, dialysis, 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.)

____
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____

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

(*sign in the presence of two witnesses; you and your witnesses must also acknowledge your signatures before a notary*)

21. Signed:___________________________________ Date: _______________________

At: (City) _______________________________ (State) ______________________

Statement of Witnesses

22. I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

23. 1st Witness: ____
(Signature)

___________________________________ _______________________
(Name Printed) (Date)

____
(Residence Address)

24. 2nd Witness: ____
(Signature)

___________________________________ _______________________
(Name Printed) (Date)

____
(Residence Address)

REQUIRED CERTIFICATE OF NOTARY PUBLIC
25. State of WEST VIRGINIA,

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_______.

Date my commission expires:___________________________ SEAL:

____
Signature of Notary Public