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,_____,
(Insert your name)

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 decision 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. I am at least 18 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, nor 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.

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