Opt In ☐ **INDICATE** in the box if you agree to have your Living Will, Medical Power of Attorney, Combined Medical Power of Attorney and Living Will, Voluntary Non-Opioid Advance Directive, POST form, and/or DNR card (if completed) included in the WV e-Directive registry and released to treating health care providers.

REGISTRY FAX: 844-616-1415

Last Name/First/Middle _____

Address _____

City/State/Zip _____

Date of Birth (mm/dd/yyyy) _____/_____/_____

Last 4 SSN ___ ___ ___ ___ **Sex M**___ **F**___

Email address _____

STATE OF WEST VIRGINIA
LIVING WILL

The Kind of Medical Treatment I Want and Don't Want If I Have a Terminal Condition or Am In a Persistent Vegetative State

Living will made this _____ day of _____ (month, year).

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. 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:

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that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn.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.

I am giving the following 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).

_____

_____

_____

Principal Name (person for whom form is being completed): _____

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.

_____ _____
Signed Date

_____
Address

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, 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 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:_____

_____
Signature of Notary Public