STATE OF WEST VIRGINIA LIVING WILL

The Kind of Medical Treatment I Want and Do Not 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that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn.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 give the following SPECIAL DIRECTIVES OR LIMITATIONS:

_____

_____

_____

_____

_____

_____

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.

PRINCIPAL SIGNATURE

I understand the full import of this living will.

Signature of Principal: _____

Print Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

WITNESS SIGNATURES

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.

Witness Signature: _____

Witness Name: _____

Address: _____

Telephone Number: _____

Witness Signature: _____

Witness Name: _____

Address: _____

Telephone Number: _____

NOTARY

State of West Virginia)

SS.

County of _____)

_____ 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