Print Form

Opt In ☐ **INITIAL box if you agree to have this advance directive submitted to the WV e-Directive Registry, and released to treating health care providers. Complete information to RIGHT.**

REGISTRY FAX: 844-616-1415

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Date of Birth (mm/dd/yyyy) _____/_____/_____
Last 4 SSN ___ ___ ___ ___ **Gender** M__ F___

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 medicalintervention, 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that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn.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: (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 want or refuse certain treatments.)

_____

_____

_____

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

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

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 _____ 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