Full Name (Last, First, Middle): _____

Address: _____

City/State/Zip: _____

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

Last 4 SSN: _____ _____ _____ _____ Sex: M_____ F_____

WV e-Directive Registry Opt In HTTPS://WVENDOFLIFE.ORG/REGISTRY

The WV e-Directive Registry makes your forms immediately available to your health care providers in emergencies. If you agree to have this form and any other submitted forms included in the WV e-Directive registry and released to treating health care providers, please mark below.

_____ YES, I OPT IN

_____ NO, I DON'T OPT IN

Registry toll-free number: 877-209-8086 **Registry FAX: 844-616-1415**

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 and address)

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 not able to do so myself.

The person I choose as my representative is (One person):

_____

_____
(Insert the name, address, area code, and telephone number of the person you wish to designate as your representative. **Please insert only one name.**)

The person I choose as my successor representative is (One person):

If my representative is unable, unwilling, or disqualified to serve, then I appoint

_____

_____
(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.**)

Principal Name: _____

(Insert your 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 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.

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.

_____ DATE _____

Signature of the Principal *(Sign your name)*

_____

Address of the Principal *(Write your full address)*

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:_____

_____

Signature of Notary Public

Insert Notary Stamp Above