WEST VIRGINIA CODE: §16-30-4

§16-30-4. Executing a living will, medical power of attorney, or combined medical power of attorney and living will.

(a) Any competent adult may execute at any time a living will, medical power of attorney, or combined medical power of attorney and living will. A living will, medical power of attorney, or combined medical power of attorney and living will made pursuant to this article shall be: (1) In writing; (2) executed by the principal or by another person in the principal's presence at the principal's express direction if the principal is physically unable to do so; (3) dated; (4) signed in the presence of two or more witnesses eat least 18 years of age; and (5) signed and attested by such witnesses whose signatures and attestations shall be acknowledged before a notary public.

(b) In addition, a witness may not be:

(1) The person who signed the living will, medical power of attorney, or combined medical power of attorney and living will on behalf of and at the direction of the principal;

(2) Related to the principal by blood or marriage;

(3) Entitled to any portion of the estate of the principal under any will of the principal or codicil thereto: *Provided,* That the validity of the living will, medical power of attorney, or combined medical power of attorney and living will may not be affected when a witness at the time of witnessing the living will, medical power of attorney, or combined medical power of attorney and living will was unaware of being a named beneficiary of the principal's will;

(4) Directly financially responsible for the principal's medical care;

(5) The attending physician; or

(6) The principal's medical power of attorney representative or successor medical power of attorney representative.

(c) The following persons may not serve as a medical power of attorney representative or successor medical power of attorney representative:

(1) A treating health care provider of the principal;

(2) An employee of a treating health care provider not related to the principal;

(3) An operator of a health care facility serving the principal; or

(4) Any person who is an employee of an operator of a health care facility serving the principal and who is not related to the principal.

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(d) It is the responsibility of the principal or his or her representative to provide for notification to his or her attending physician and other health care providers of the existence of the living will, medical power of attorney, or combined medical power of attorney and living will or a revocation of the living will, medical power of attorney, or combined medical power of attorney and living will. An attending physician or other health care provider, when presented with the living will, medical power of attorney, or combined medical power of attorney and living will, or the revocation of a living will, medical power of attorney, or combined medical power of attorney and living will, shall make the living will, medical power of attorney, or combined medical power of attorney and living will, or a copy or revocation of any, a part of the principal's medical records.

(e) At the time of admission to any health care facility, each person shall be advised of the existence and availability of living will, medical power of attorney, and combined medical power of attorney and living will forms and shall be given assistance in completing such forms if the person desires: *Provided,* That under no circumstances may admission to a health care facility be predicated upon a person having completed a living will, medical power of attorney, or combined medical power of attorney and living will.

(f) The provision of living will, medical power of attorney, or combined medical power of attorney and living will forms substantially in compliance with this article by health care providers, medical practitioners, social workers, social service agencies, senior citizens centers, hospitals, nursing homes, personal care homes, community care facilities, or any other similar person or group, without separate compensation, does not constitute the unauthorized practice of law.

(g) The living will may, but need not, be in the following form and may include other specific directions not inconsistent with other provisions of this article. Should any of the other specific directions be held to be invalid, the invalidity may not affect other directions of the living will which can be given effect without the invalid direction and to this end the directions in the living will are severable.

STATE OF WEST VIRGINIA

LIVING WILL

The Kind of Medical Treatment I Want and Don't Want

If I Have a Terminal Condition

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

I,_____, (*Insert your name)*

being of sound mind, willfully and voluntarily declare that I want my wishes to be respected

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if I am very sick and unable to communicate my wishes for myself. In the absence of my ability to give directions regarding the use of life-prolonging intervention, it is my desire that my dying may not be prolonged under the following circumstances:

If I am very sick and unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, I direct that life-prolonging intervention that would serve solely to prolong the dying process be withheld or withdrawn. I understand that by signing this document I am agreeing to the REMOVAL or REFUSAL of cardiopulmonary resuscitation (CPR), breathing machine (ventilator), dialysis, and medically administered food and fluids, such as might be provided intravenously or by feeding tube. 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. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

I give the following SPECIAL DIRECTIVES OR LIMITATIONS: (Comments about funeral arrangements, autopsy, mental health treatment, 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.)

_____

_____

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

_____

_____

Address

I did not sign the principal's signature above for or at the direction of the principal. I am at least 18 years of age and am not related to the principal by blood or marriage, nor entitled to any portion of the estate of the principal to the best of my knowledge under any will of principal or codicil thereto, nor directly financially responsible for principal's medical care. I am not the principal's attending physician or the principal's medical power of attorney

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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:_____

_____

Notary Public

(h) A medical power of attorney may, but need not, be in the following form, and may include other specific directions not inconsistent with other provisions of this article. Should any of the other specific directions be held to be invalid, such invalidity may not affect other directions of the medical power of attorney which can be given effect without the invalid direction and to this end the directions in the medical power of attorney are severable.

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_____

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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

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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.

_____

Signature of the 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

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_____

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

(i) A combined medical power of attorney and living will may, but need not, be in the following form, and may include other specific directions not inconsistent with other provisions of this article. Should any of the other specific directions be held to be invalid, the invalidity does not affect other directions of the combined medical power of attorney and living will which can be given effect without the invalid direction and to this end the directions in the combined medical power of attorney and living will are severable.

STATE OF WEST VIRGINIA

COMBINED MEDICAL POWER OF ATTORNEY AND LIVING WILL

The Person I Want to Make Health Care Decisions for Me When I Can't Make

Them for Myself and the Kind of Medical Treatment I Want and Don't Want

If I Have a Terminal Condition

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:

_____

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_____

(*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. Such authority shall include, but not be limited to, decisions regarding the withholding or withdrawal of life-prolonging interventions, subject to the special directives and limitations as stated below:

1. IN A TERMINAL CONDITION: If I am very sick and unable to communicate my wishes for myself and I am certified by one physician, who has personally examined me, to have a terminal condition, I direct that life-prolonging intervention that would serve solely to prolong the dying process be withheld or withdrawn. Thus, if a physician has determined that I am in a terminal condition, I understand that completing this form would mean that I refuse cardiopulmonary resuscitation (CPR). It also means that I refuse or request the removal of a breathing machine (ventilator), dialysis, and medically administered food and fluids, such as might be provided intravenously or by feeding tube. 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. Nevertheless, oral food and fluids, such as may be provided by spoon or by straw, shall be offered as desired and can be tolerated.

2. OTHER Living Will SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (Comments about 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.)

_____

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_____

_____

_____

_____

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated in this advance directive.

3. NOT IN A TERMINAL CONDITION: Medical Power of Attorney 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.)

_____

_____

_____

_____

_____

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.

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD, OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

_____

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Signature of the 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 nor 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

(j) Any and all living will, medical power of attorney, and combined medical power of attorney and living will documents executed pursuant to §16-30-3 and §16-30-4 of this code, before the effective date of the amendments to these sections, remain in full force and effect. This section is effective for a living will, medical power of attorney, or combined medical power of attorney and living will document executed, amended, or adjusted on or after January 1, 2023. Accordingly, all health care facilities and health care providers using a living will, medical power of attorney, or combined medical power of attorney and living will form referenced in §16-30-4 of this code shall update their forms on or before January 1, 2023.

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