

HB 3093 3

FILED

2007 APR -4 AM 11:20

OFFICE WEST VIRGINIA
SECRETARY OF STATE

WEST VIRGINIA LEGISLATURE
FIRST REGULAR SESSION, 2007



ENROLLED

**COMMITTEE SUBSTITUTE
FOR
House Bill No. 3093**

(By Delegate Perdue)



Passed March 10, 2007

In Effect Ninety Days from Passage

ENROLLED

FILED

2007 APR -4 AM 11:20

COMMITTEE SUBSTITUTE

FOR

OFFICE WEST VIRGINIA
SECRETARY OF STATE

H. B. 3093

(BY DELEGATE PERDUE)

(Passed March 10, 2007; in effect ninety days from passage.)

AN ACT to amend and reenact §16-30-4 of the Code of West Virginia, 1931, as amended, relating to providing a form for a combined medical power of attorney and living will.

Be it enacted by the Legislature of West Virginia:

That §16-30-4 of the Code of West Virginia, 1931, as amended, be amended and reenacted to read as follows:

ARTICLE 30. WEST VIRGINIA HEALTH CARE DECISIONS ACT.

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

- 1 (a) Any competent adult may execute at any time a living
- 2 will or medical power of attorney. A living will or medical
- 3 power of attorney made pursuant to this article shall be: (1)

4 In writing; (2) executed by the principal or by another person
5 in the principal's presence at the principal's express direction
6 if the principal is physically unable to do so; (3) dated; (4)
7 signed in the presence of two or more witnesses at least
8 eighteen years of age; and (5) signed and attested by such
9 witnesses whose signatures and attestations shall be
10 acknowledged before a notary public as provided in
11 subsection (d) of this section.

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

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

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

17 (3) Entitled to any portion of the estate of the principal
18 under any will of the principal or codicil thereto: *Provided,*
19 That the validity of the living will or medical power of
20 attorney shall not be affected when a witness at the time of
21 witnessing such living will or medical power of attorney was
22 unaware of being a named beneficiary of the principal's will;

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

25 (5) The attending physician; or

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

29 (c) The following persons may not serve as a medical
30 power of attorney representative or successor medical power
31 of attorney representative: (1) A treating health care provider
32 of the principal; (2) an employee of a treating health care
33 provider not related to the principal; (3) an operator of a
34 health care facility serving the principal; or (4) any person
35 who is an employee of an operator of a health care facility
36 serving the principal and who is not related to the principal.

37 (d) It shall be the responsibility of the principal or his or
38 her representative to provide for notification to his or her
39 attending physician and other health care providers of the
40 existence of the living will or medical power of attorney or a
41 revocation of the living will or medical power of attorney.
42 An attending physician or other health care provider, when
43 presented with the living will or medical power of attorney,
44 or the revocation of a living will or medical power of
45 attorney, shall make the living will, medical power of
46 attorney or a copy of either or a revocation of either a part of
47 the principal's medical records.

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

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

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

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

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

75 I, _____, being of
76 sound mind, willfully and voluntarily declare that I want my
77 wishes to be respected if I am very sick and not able to
78 communicate my wishes for myself. In the absence of my
79 ability to give directions regarding the use of life-prolonging
80 medical intervention, it is my desire that my dying shall not
81 be prolonged under the following circumstances:

82 If I am very sick and not able to communicate my wishes
83 for myself and I am certified by one physician, who has
84 personally examined me, to have a terminal condition or to
85 be in a persistent vegetative state (I am unconscious and am
86 neither aware of my environment nor able to interact with
87 others), I direct that life-prolonging medical intervention that
88 would serve solely to prolong the dying process or maintain
89 me in a persistent vegetative state be withheld or withdrawn.
90 I want to be allowed to die naturally and only be given
91 medications or other medical procedures necessary to keep
92 me comfortable. I want to receive as much medication as is
93 necessary to alleviate my pain.

94 I give the following SPECIAL DIRECTIVES OR
95 LIMITATIONS: (Comments about tube feedings, breathing
96 machines, cardiopulmonary resuscitation, dialysis and mental
97 health treatment may be placed here. My failure to provide
98 special directives or limitations does not mean that I want or
99 refuse certain treatments.)

100

101

102

103

104 It is my intention that this living will be honored as the
105 final expression of my legal right to refuse medical or
106 surgical treatment and accept the consequences resulting
107 from such refusal.

108 I understand the full import of this living will.

109
110 Signed
111

112
113 Address

114 I did not sign the principal's signature above for or at the
115 direction of the principal. I am at least eighteen years of age
116 and am not related to the principal by blood or marriage,
117 entitled to any portion of the estate of the principal to the best
118 of my knowledge under any will of principal or codicil
119 thereto, or directly financially responsible for principal's
120 medical care. I am not the principal's attending physician or
121 the principal's medical power of attorney representative or
122 successor medical power of attorney representative under a
123 medical power of attorney.

124
125 Witness DATE
126
127
128 Witness DATE

129 _____
130 STATE OF

131 _____
132 COUNTY OF

133 I, _____, a Notary Public of said
134 County, do certify that _____, as
135 principal, and _____ and _____, as
136 witnesses, whose names are signed to the writing above
137 bearing date on the _____ day of _____, 20____,
138 have this day acknowledged the same before me.

139 Given under my hand this _____ day of _____, 20__.

140 My commission expires: _____

141

142 Notary Public

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

151 **STATE OF WEST VIRGINIA**
152 **MEDICAL POWER OF ATTORNEY**

**The Person I Want to Make Health Care Decisions
For Me When I Can't Make Them for Myself**

153 Dated: _____, 20_____

154 I, _____, hereby
155 (Insert your name and address)

156 appoint as my representative to act on my behalf to give,
157 withhold or withdraw informed consent to health care
158 decisions in the event that I am not able to do so myself.

159 **The person I choose as my representative is:**

160

161 *(Insert the name, address, area code and telephone*
162 *number of the person you wish to designate as your*
163 *representative)*

164 **The person I choose as my successor representative is:**

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

167

168 *(Insert the name, address, area code and telephone*
169 *number of the person you wish to designate as your*
170 *successor representative)*

171

172 This appointment shall extend to, but not be limited to,
173 health care decisions relating to medical treatment, surgical
174 treatment, nursing care, medication, hospitalization, care and
175 treatment in a nursing home or other facility, and home
176 health care. The representative appointed by this document
177 is specifically authorized to be granted access to my medical
178 records and other health information and to act on my behalf
179 to consent to, refuse or withdraw any and all medical
180 treatment or diagnostic procedures, or autopsy if my
181 representative determines that I, if able to do so, would
182 consent to, refuse or withdraw such treatment or procedures.
183 Such authority shall include, but not be limited to, decisions
184 regarding the withholding or withdrawal of life-prolonging
interventions.

185

186 I appoint this representative because I believe this person
187 understands my wishes and values and will act to carry into
188 effect the health care decisions that I would make if I were
189 able to do so and because I also believe that this person will
190 act in my best interest when my wishes are unknown. It is
191 my intent that my family, my physician and all legal
192 authorities be bound by the decisions that are made by the
193 representative appointed by this document and it is my intent
194 that these decisions should not be the subject of review by
any health care provider or administrative or judicial agency.

195

196 It is my intent that this document be legally binding and
197 effective and that this document be taken as a formal
198 statement of my desire concerning the method by which any
199 health care decisions should be made on my behalf during
any period when I am unable to make such decisions.

200

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

203 I am giving the following SPECIAL DIRECTIVES OR
204 LIMITATIONS ON THIS POWER: (Comments about tube
205 feedings, breathing machines, cardiopulmonary resuscitation,
206 dialysis, funeral arrangements, autopsy and organ donation
207 may be placed here. My failure to provide special directives
208 or limitations does not mean that I want or refuse certain
209 treatments.)
210
211

212 THIS MEDICAL POWER OF ATTORNEY SHALL
213 BECOME EFFECTIVE ONLY UPON MY INCAPACITY
214 TO GIVE, WITHHOLD OR WITHDRAW INFORMED
215 CONSENT TO MY OWN MEDICAL CARE.
216
217 Signature of the Principal

218 I did not sign the principal's signature above. I am at
219 least eighteen years of age and am not related to the principal
220 by blood or marriage. I am not entitled to any portion of the
221 estate of the principal or to the best of my knowledge under
222 any will of the principal or codicil thereto, or legally
223 responsible for the costs of the principal's medical or other
224 care. I am not the principal's attending physician, nor am I
225 the representative or successor representative of the principal.
226

227 Witness: DATE

228

229 _____
230 Witness: DATE

231

232 STATE OF

233

234 COUNTY OF

235 I, _____, a Notary Public of said
236 County, do certify that _____, as
237 principal, and _____ and _____, as
238 witnesses, whose names are signed to the writing above

239 bearing date on the _____ day of _____, 20____,
240 have this day acknowledged the same before me.

241 Given under my hand this _____ day of _____, 20____

242 My commission expires: _____

243 _____

244 Notary Public

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

255 **STATE OF WEST VIRGINIA**
256 **COMBINED MEDICAL POWER OF ATTORNEY**
257 **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 or Am In a
Persistent Vegetative State**

258 Dated: _____, 20____

259 I, _____, hereby
260 *(Insert your name and address)*

261 appoint as my representative to act on my behalf to give,
262 withhold or withdraw informed consent to health care
263 decisions in the event that I am not able to do so myself.

264 The person I choose as my representative is:

265

266 *(Insert the name, address, area code and telephone number*
267 *of the person you wish to designate as your representative).*

268 If my representative is unable, unwilling or disqualified
269 to serve, then I appoint as my successor representative:
270
271 *—*
272 *(Insert the name, address, area code and telephone number*
273 *of the person you wish to designate as your successor*
representative).

274 This appointment shall extend to, but not be limited to,
275 health care decisions relating to medical treatment, surgical
276 treatment, nursing care, medication, hospitalization, care and
277 treatment in a nursing home or other facility, and home
278 health care. The representative appointed by this document
279 is specifically authorized to be granted access to my medical
280 records and other health information and to act on my behalf
281 to consent to, refuse or withdraw any and all medical
282 treatment or diagnostic procedures, or autopsy if my
283 representative determines that I, if able to do so, would
284 consent to, refuse or withdraw such treatment or procedures.
285 Such authority shall include, but not be limited to, decisions
286 regarding the withholding or withdrawal of life-prolonging
287 interventions.

288 I appoint this representative because I believe this person
289 understands my wishes and values and will act to carry into
290 effect the health care decisions that I would make if I were
291 able to do so, and because I also believe that this person will
292 act in my best interest when my wishes are unknown. It is
293 my intent that my family, my physician and all legal
294 authorities be bound by the decisions that are made by the
295 representative appointed by this document, and it is my intent
296 that these decisions should not be the subject of review by
297 any health care provider or administrative or judicial agency.

298 It is my intent that this document be legally binding and
299 effective and that this document be taken as a formal
300 statement of my desire concerning the method by which any
301 health care decisions should be made on my behalf during
302 any period when I am unable to make such decisions.

303 In exercising the authority under this medical power of
304 attorney, my representative shall act consistently with my
305 special directives or limitations as stated below.

306 I am giving the following SPECIAL DIRECTIVES OR
307 LIMITATIONS ON THIS POWER: (Comments about tube
308 feedings, breathing machines, cardiopulmonary resuscitation,
309 dialysis, mental health treatment, funeral arrangements,
310 autopsy, and organ donation may be placed here. My failure
311 to provide special directives or limitations does not mean that
312 I want or refuse certain treatments).

313 1. If I am very sick and not able to communicate my
314 wishes for myself and I am certified by one physician who
315 has personally examined me, to have a terminal condition or
316 to be in a persistent vegetative state (I am unconscious and
317 am neither aware of my environment nor able to interact with
318 others,) I direct that life-prolonging medical intervention that
319 would serve solely to prolong the dying process or maintain
320 me in a persistent vegetative state be withheld or withdrawn.
321 I want to be allowed to die naturally and only be given
322 medications or other medical procedures necessary to keep
323 me comfortable. I want to receive as much medication as is
324 necessary to alleviate my pain.

325 2. Other directives: _____
326
327
328
329

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

334
335 Signature of the Principal

336 I did not sign the principal's signature above. I am at least
337 eighteen years of age and am not related to the principal by
338 blood or marriage. I am not entitled to any portion of the
339 estate of the principal or to the best of my knowledge under
340 any will of the principal or codicil thereto, or legally
341 responsible for the costs of the principal's medical or other
342 care. I am not the principal's attending physician, nor am I
343 the representative or successor representative of the principal.

344 Witness _____ DATE _____
345 Witness _____ DATE _____
346 STATE OF _____
347 COUNTY OF _____

348 I, _____, a Notary Public of said
349 county, do certify that _____, as principal,
350 and _____ and _____,
351 as witnesses, whose names are signed to the writing above
352 bearing date on the ____ day of _____, 20 ____,
353 have this day acknowledged the same before me.

354 Given under my hand this ____ day of _____, 20 __.

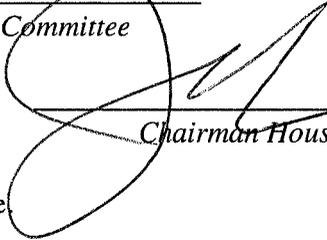
355 My commission expires: _____

356 _____
357 Signature of Notary Public

That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.



Chairman Senate Committee



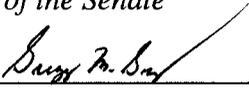
Chairman House Committee

Originating in the House

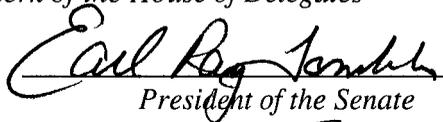
In effect ninety days from passage.



Clerk of the Senate



Clerk of the House of Delegates

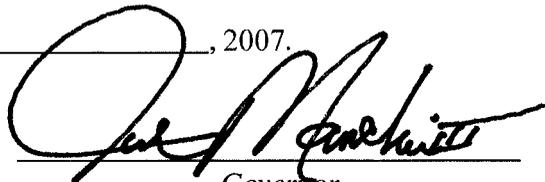


President of the Senate



Speaker of the House of Delegates

The within is approved this the 2nd
day of April, 2007.



Governor

PRESENTED TO THE
GOVERNOR

MAR 26 2007

Time 4:00pm