~ West Virginia ~
Medical Power of Attorney
Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your "medical power of attorney representative" or "representative." You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your representative. If your health care representative is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your representative broad powers to make health care decisions for you. It revokes any prior medical power of attorney that you may have made. If you wish to change your medical power of attorney, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your representative, your health care provider(s), and any other person(s) to whom you have given a copy. If your representative is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior document of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your representative, close family, or friends, if needed.

STATE OF WEST VIRGINIA
MEDICAL POWER OF ATTORNEY

Written in accordance with West Virginia § 16-30-4

DESIGNATION OF REPRESENTATIVES

Dated: _____/_____/_____

I, _____, _____
Name Address

_____, hereby appoint 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 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 or a health care facility serving the principal; or (4) an employee of an operator of a health care facility not related to the principal.

The person I choose as my representative is: _____,
Representative

_____, (_____) _____
Address Phone

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

_____, _____
Successor representative Address

_____, (_____) _____
Phone

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 in 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.

I appoint this representative because I believe this person understand 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 limitation as stated in this document.

SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER:

In exercising authority under this document, my representative shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state: (Comments about tube feedings, breathing machines, cardiopulmonary resuscitation, and dialysis may be placed here. My failure to provide special directives or limitations does not mean that I want or refuse certain treatments.)

1. I request that the attached Addendum (pages 6-11) be included as a valid part of this Medical Power of Attorney document.

2. I request, but not as a requirement, that my medical power of attorney representative consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

[Attach additional pages, if needed.]

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

The principal must sign in the presence of two qualified witnesses at least 18 years of age and acknowledged before a notary public.

SIGNATURE OF PRINCIPAL

(Person creating this Medical Power of Attorney)

Signature: _____ Date: _____

(The signing of this document by the principal revokes all previous medical powers of attorney.)

STATEMENT OF WITNESSES

I did not sign the principal's signature above. I am at least eighteen 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, or 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 #1

Print name: _____ Date: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Signature: _____

NOTARY PUBLIC

_____

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 _____ (Month), _____ (Year) have this day acknowledged the same before me.

Given under my hand this _____ day of _____ (Month), _____ (Year).

My commission expires: _____

Signature: _____

Notary Public

STATEMENT OF MEDICAL POWER OF ATTORNEY REPRESENTATIVE

I understand that _____ has designated me to be his or her medical
Name of principal
power of attorney representative if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Representative's signature: _____

Address: _____

STATEMENT OF SUCCESSOR MEDICAL POWER OF ATTORNEY REPRESENTATIVE

I understand that _____ has designated me to be his or her successor
Name of principal
medical power of attorney representative if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as medical power of attorney representative is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Successor representative's signature: _____

Address: _____

ADDENDUM TO THE WEST VIRGINIA MEDICAL POWER OF ATTORNEY

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care representative to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care representative has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care representative to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care representative may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care representative may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care representative may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care representative may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Medical Power of Attorney document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care representative may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care representative may not have a feeding tube withheld or withdrawn from me.

My health care representative may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care representative may not have a feeding tube withheld or withdrawn from me.

ADMISSION TO NURSING HOMES

My health care representative may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care representative may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care representative may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care representative may only admit me for short–term stays for recuperative care or respite care.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care representative is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care representative may make health care decisions for me even if my representative knows I am pregnant. If I have checked "No" to the following, my health care representative may not make health care decisions for me if my health care representative knows I am pregnant.

Health care decision if I am pregnant **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care representative may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care representative authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care representative has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my health care representative to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my representative the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

The principal must sign in the presence of two qualified witnesses at least 18 years of age and acknowledged before a notary public.

SIGNATURE OF PRINCIPAL

(Person creating this Medical Power of Attorney)

Signature: _____ Date: _____

(The signing of this document by the principal revokes all previous medical powers of attorney.)

STATEMENT OF WITNESSES

I did not sign the principal's signature above. I am at least eighteen 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, or 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 #1

Print name: _____ Date: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Signature: _____

NOTARY PUBLIC

_____

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 _____, _____ have this day acknowledged the same before me.
Month Year

Given under my hand this _____ day of _____, _____.
Month Year

My commission expires: _____

Signature: _____
Notary Public

STATEMENT OF MEDICAL POWER OF ATTORNEY REPRESENTATIVE

I understand that _____ has designated me to be his or her medical
Name of principal
power of attorney representative if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Representative's signature: _____

Address: _____

STATEMENT OF SUCCESSOR MEDICAL POWER OF ATTORNEY REPRESENTATIVE

I understand that _____ has designated me to be his or her successor
Name of principal
medical power of attorney representative if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as medical power of attorney representative is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Successor representative's signature: _____

Address: _____

CLERGY
Optional

The principal has requested that the representative consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the representative to help meet the directives as described in this Medical Power of Attorney document and attached Addendum.

Clergy's signature: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Medical Power of Attorney – Christian Version to:

_____ _____

_____ _____

_____ _____