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Houston TX 77045  
MedicalDirectives.net  
T/F: 866 -300-7388

Thank you for downloading the PDF-fillable form for your Medical Directive, Advance Medical Directive, or Medical Power of Attorney. The process is very straightforward:

1. Choose the subscription type you want and pay online. We use paypal for all credit card processing and NEVER store your Credit Card Information.
2. Download the form to your computer.
3. Fill it out on your computer and print it.
4. Take the filled-form to your favorite notary (or your witnesses) and have it notarized or witnessed.
5. Fax your paperwork to 866-300-7388. If you want to email it instead, please SCAN all to PDF utilizing 200 DPI scan settings, making 1 PDF file, and email to [forms@medicaldirectives.net](mailto:forms@medicaldirectives.net)
6. Your Retrieval Card is emailed out to you within 24 hours of receiving your medical directive. If you lose it or need another one, you can generate one easily on our web portal .

Here is the form for the state you selected. Please do not fax back any instruction sheets. We do not require a coversheet when you fax.

**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: 304-293-7442**

Last Name/First/Middle \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Date of Birth (mm/dd/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last 4 SSN \_\_\_\_ \_ Gender M\_\_ F\_\_

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 or Am In a Persistent Vegetative State

Dated: \_\_\_\_\_, 20\_\_\_\_\_

I, \_\_\_\_\_, hereby  
(Insert your name and address)

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:**

\_\_\_\_\_

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

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

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)

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.

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.

I am giving the following 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).

1. 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.

2. Other directives: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 DATE \_\_\_\_\_

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 \_\_\_\_\_ 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

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Last 4 SSN \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_ Gender M\_\_\_\_ F\_\_\_\_

**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, \_\_\_\_\_, hereby  
*(Insert your name and address)*

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:**

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

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

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)*

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.

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.



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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 medical intervention, 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.)

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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

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