STATE OF WEST VIRGINIA
LIVING WILL

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that would serve solely to prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn.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.)

_____

_____

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 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: _____

_____
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 shall not affect other directions of the medical power of attorney which can be given effect without invalid direction and to this end the directions in the medical power of attorney are severable.