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## ***Frequently Asked Questions about the Combined Living Will/Medical Power of Attorney***

- ***Can I combine my living will and medical power of attorney in one form?***  
Yes. You can use one document that combines both the living will and the medical power of attorney forms.
- ***Can I still make my own healthcare decisions once I have completed a combined form?***  
Yes. Your combined form will does not take effect until you cannot make decisions for yourself. The living will portion of the combined form takes effect when you are terminally ill or permanently unconscious. As long as you can make your own decisions, the form is NOT in effect.
- ***Can any person create a combined form?***  
Yes. Any adult (including a mature or emancipated minor) who has the ability to make decisions for him or herself can complete a combined form.
- ***Do I need a lawyer to create a combined form?***  
No. A combined form can be completed without the help of a lawyer.
- ***Will another state honor my combined form?***  
Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored.
- ***What should I do with my combined form after I sign it?***  
After your form is signed, witnessed, and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your combined form is legally valid. You are encouraged to send a copy of your combined form to the West Virginia e-Directive Registry. See instructions below.

A complete listing of all Frequently Asked Questions relating to the Combined Living Will/Medical Power of Attorney can be found by clicking on this [FAQS link](http://wvendlife.org/for-patients/faqs/) on this page or by visiting <http://wvendlife.org/for-patients/faqs/>.

**So that your combined form can be found in a medical emergency, you are encouraged to submit your form to the WV e-Directive Registry by FAXing it to 844-616-1415 or mailing a copy to the WV e-Directive Registry, 64 Medical Center Drive, PO Box 9022 Health Sciences North, Morgantown, WV 26506. The combined living/medical power of attorney on this site contains an Opt-In box. If you would like to have your combined form included in the Registry, you must INDICATE in the box giving your permission.**

**Opt In**  INDICATE in the box if you agree to have your Living Will, Medical Power of Attorney, Combined Medical Power of Attorney and Living Will, Voluntary Non-Opioid Advance Directive, POST form, and/or DNR card (if completed) included in the WV e-Directive registry and released to treating health care providers.

**REGISTRY FAX: 844-616-1415**

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

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)

Principal Name (person for whom form is being completed): \_\_\_\_\_

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