

**STATE OF WEST VIRGINIA  
LIVING WILL**

Living will made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year).

I, \_\_\_\_\_, being of sound mind, willfully and voluntarily declare that in the absence of my ability to give directions regarding the use of life-prolonging intervention, it is my desire that my dying shall not be artificially prolonged under the following circumstances:

If at any time I should be certified by two physicians who have personally examined me, one of whom is my attending physician, to have a terminal condition or to be in a persistent vegetative state, I direct that life-prolonging intervention that would serve solely to artificially prolong the dying process or maintain me in a persistent vegetative state be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any other medical procedure deemed necessary to keep me comfortable and alleviate pain.

SPECIAL DIRECTIVES OR LIMITATIONS ON THIS DECLARATION: (If none, write "none".)

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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 \_\_\_\_\_

Address \_\_\_\_\_

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*(Over)*

I did not sign the declarant's signature above for or at the direction of the declarant. I am at least eighteen years of age and am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the state of the declarant's domicile or to the best of my knowledge under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician or the declarant's health care representative, proxy or successor health care representative under a medical power of attorney.

Witness \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_



The foregoing instrument was acknowledged before me this \_\_\_\_\_  
\_\_\_\_\_ (date) by the declarant and by the two  
witnesses whose signatures appear above.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

# Wallet Cards for Advance Directives

Cut out and complete the cards below. Put one card in the wallet or purse you carry most often, along with your driver's license or health insurance card. Keep the second card on your refrigerator, in your motor vehicle glove compartment, a spare wallet or purse, or other easy-to-find place.

 **ATTENTION HEALTH CARE PROVIDERS** 



I have created the following Advance Directive:  
*(Check one or both, as appropriate)*



Medical Power of Attorney  
 Living Will

Please contact \_\_\_\_\_  
*(Name)*

\_\_\_\_\_ *(Address)*

\_\_\_\_\_ for more information.  
*(Telephone)*

\_\_\_\_\_  \_\_\_\_\_  
Date Signature 

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*(Check one or both, as appropriate)*

Medical Power of Attorney  
 Living Will

Please contact \_\_\_\_\_  
*(Name)*

\_\_\_\_\_ *(Address)*

\_\_\_\_\_ for more information.  
*(Telephone)*

\_\_\_\_\_  \_\_\_\_\_  
Date Signature 