



1-877-209-8086

www.wvendoflife.org

**Advance Directives for
Health Care Decision-Making in West Virginia**

Frequently Asked Questions and Forms

FORMS INSIDE:

Living Will

Medical Power of Attorney

Combined Living Will & Medical Power of Attorney

WV e-Directive Registry Sign-up Form



FAX 844-616-1415

This booklet is based on the West Virginia Health Care Decisions Act passed by the West Virginia Legislature in March 2000 and amended in 2002 and 2007. The Center hopes that this booklet will be of assistance to West Virginians in understanding and completing advance directives. The Center's website at www.wvendoflife.org contains a copy of the West Virginia Health Care Decisions Act and additional forms that can be downloaded. The information in this booklet is not considered to be legal advice.

Revised July 2020

What are “Advance Directives for Health Care Decision-Making?”

Why are They Important?

As an adult, you have the right to make your own health care decisions. Your doctor and other health care providers must tell you about the nature of any proposed procedure or treatment, its probable benefits or effects, and any predictable discomfort, complications, or risks. You have the right to know about alternative treatments and their risks and benefits. You have the right to ask questions, and then you have the right to decide whether you want the treatment or not. Your right to accept medical or surgical treatment also includes the right to refuse it.

What if you become incapable of making health care decisions for yourself because of injury or illness? Imagine that you are in a hospital, terminally ill with cancer, and are confused. Who will decide whether you should have CPR (cardiopulmonary resuscitation) if your heart should stop suddenly? What if you are 40 years old and are involved in a motor vehicle accident which leaves you permanently unconscious? Who will decide whether you are to be kept alive with tube feedings? What if you have Alzheimer’s disease, and you develop a serious infection in a nursing home? Who will decide whether or not you will be hospitalized and treated with antibiotics?

“West Virginia Law Recognizes Two Types of Advance Directives . . . The Living Will and the Medical Power of Attorney.”

You can remain in charge of your health care, even after you can no longer make decisions for yourself, by creating a document called an “advance directive.”

West Virginia law recognizes two types of written advance directives for health care decision-making: the living will and the medical power of attorney. This booklet presents information about these directives and includes the appropriate forms. Both forms have a special section for you to write in specific comments about circumstances in which you would not want CPR, a feeding tube, dialysis, treatment with a breathing machine, or other preferences. You should discuss these comments with your family and doctors so they can better understand what is important to you in receiving medical treatment. Should you wish to have both forms in one document, there is also a combined living will/medical power of attorney form in this booklet.

You can use these documents to let your family and doctor know your decisions for health care if you become unable to decide for yourself. You can appoint someone you know and trust as your medical power of attorney representative to ensure that your choice or decision is honored.

Submit your Advance Directive Forms to the WV e-Directive Registry

The West Virginia Center for End-of-Life Care (WVCEOLC) through the WV Health Information Network (WVHIN) has established the WV e-Directive Registry. With the permission of patients, this electronic registry houses and makes available to treating health care providers West Virginians’ advance directive forms, Do Not Resuscitate cards, Physician Orders for Scope of Treatment (POST) forms, and other forms. This password-protected, HIPAA-compliant Registry allows accurate, relevant information about patients’ advance directives and medical orders to be available to treating health care providers in a medical crisis. The WV e-Directive Registry is accessible 24/7 to treating health care providers through WVHIN and ensures that patients’ wishes will be respected throughout the continuum of health care settings. This Registry is also available to EMS providers to search for patients en route to emergency calls.

For more information on the WV e-Directive Registry, visit our website, wvendlife.org.

“Opt-In” to have Your Forms Available through the WV e-Directive Registry

The advance directive forms contained in this booklet contain an Opt-In box. If you would like to have your advance directive forms included in the Registry, you must **INDICATE** in the box giving your permission to do so and **fax** the forms to the Registry at 844-616-1415 or **mail** a copy of your forms to the Registry at PO Box 9022, Morgantown, WV 26506. If your advance directive form is older and does not contain the Opt-In box at the top left corner, you can complete the WV e-Directive Registry Sign-Up form contained in this booklet and fax or mail it along with your older forms.

You may submit your advance directive forms, do not resuscitate card, or Physician Orders for Scope of Treatment (POST) form to the WV e-Directive Registry by faxing the forms to 844-616-1415. You may mail a **copy** of your forms to the WV e-Directive Registry, 64 Medical Center Drive, PO Box 9022 Health Sciences North, Morgantown, WV 26506.-9022

Frequently Asked Questions about Advance Directives

1. *What is a living will?*

A living will is a legal document that tells your doctor how you want to be treated if you are terminally ill or permanently unconscious and cannot make decisions for yourself. A living will says that life-prolonging medical interventions that would serve solely to prolong your dying should not be used. A living will only applies if you are terminally ill or permanently unconscious AND too sick to make decisions for yourself.

2. *What is a medical power of attorney?*

A medical power of attorney is a legal document, a type of advance directive that allows you to name a person to make health care decisions for you if you are unable to make them for yourself.

3. *How is the medical power of attorney different from the living will?*

A living will only applies if you are terminally ill or permanently unconscious AND too sick to make decisions for yourself. A living will only tells your doctor what you do not want unless you write in other specific instructions. A living will is a written record of decisions that you have made yourself.

On the other hand, the medical power of attorney allows you to choose someone else to make health care decisions for you if you are too sick to make them for yourself. This person is called your legal medical power of attorney representative. Your representative can make any health care decision that you could make if you were able. A medical power of attorney allows you to give specific instructions to your representative about the type of care you would want to receive.

The medical power of attorney allows your representative to respond to medical situations that you might not have anticipated and to make decisions for you with knowledge of your values and wishes.

4. *I am a young person in good health. Do I really need to create a formal advance directive?*

Yes. Advance directives are for all adults, including mature minors and emancipated minors. We never know when an accident or serious illness will leave us incapable of making our own health care decisions.

5. *What if I already have a living will? Do I need to create a medical power of attorney?*

Most West Virginians create both a medical power of attorney and a living will. Since the medical power of attorney is a more flexible document and allows you to name someone to make decisions for you, it is advisable to create a medical power of attorney even if you have already signed a living will.

The representative you appoint as your medical power of attorney representative can help ensure that the preferences expressed in your living will are carried out. Some people, however, do not have someone whom they trust or who knows their values and preferences. These people should consider creating a living will.

If you choose to sign both documents, you should see that they are stored in the same place to help assure that your representative will know to respect all of your wishes. Alternatively, you may choose to complete a combined living will and medical power of attorney document.

6. *Should I complete a new living will or medical power of attorney if I completed one before June 11, 2000?*

On June 11, 2000, a new law went into effect that made several changes to the living will and medical power of attorney forms. Most importantly, the new law requires only one physician to decide whether you are able to make your own health care decisions. Forms completed prior to the new law require two physicians to make this determination. The new forms also are written in clearer, easy to understand language. If you want to take advantage of these changes, you should complete a new living will and medical power of attorney.

7. *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.

8. *Can I still make my own health care decisions once I have created an advance directive?*

Yes. Your living will does not become effective until you are terminally ill or permanently unconscious AND too sick to make decisions for yourself. As long as you can do this, you have the right to make your own decisions. Your medical power of attorney does not become effective until you are not able to clearly say your own wishes.

9. *If I decide to create a medical power of attorney, how should I choose my representative?*

Choose someone who knows your values and wishes, and whom you trust to make decisions for you. Do the same for a successor representative. Ask both to be sure they understand and agree to be your representative.

You may, but do not have to, choose a family member to be your representative. Regardless of your choice, your representative should be someone who will be available if needed and who will decide matters the way you would decide.

Name only one person each as your representative and your successor representative. Do not choose your doctor or another person who is likely to be your future health care provider as your representative or successor representative.

10. *What instructions should I give my representatives concerning my health care?*

You may give very general instructions and preferences or be quite specific. It would be helpful to your representatives to have directions from you about medical conditions in which you would NOT want life prolonging intervention, particularly medically administered food and water (tube feedings), cardiopulmonary resuscitation (CPR), and the use of machines to help you breathe. You should also tell your representative if you want to be an organ and tissue donor.

Many people choose to write their representatives a letter stating their personal values and wishes, their feelings about life and death, and any specific instructions, and to attach a copy of this letter to their medical power of attorney.

Talk with your representatives about your choices and personal values and beliefs. Make sure they know what is important to you. This information will help them make the decisions that you would make if you were able.

11. *Can any person create an advance directive?*

Yes. Any adult (including a mature or emancipated minor) who has the capacity to make decisions for themselves can create an advance directive.

12. *Do I need a lawyer to create an advance directive?*

No. An advance directive can be created without the assistance of a lawyer.

13. *Who should witness my signature on my advance directive?*

Your witnesses must be at least 18 years of age and not related to you by blood or marriage. Choose individuals who will not inherit any of your property. Do not choose the person you named as your representative or your successor representative or your doctor as your witness.

14. *How can I find a Notary Public to complete my medical power of attorney form?*

Businesses such as banks, insurance agents, government offices, hospitals, doctors' offices, and automobile associations have or can direct you to a notary public.

15. *What should I do with my advance directive after I sign it?*

After your advance directive is signed, witnessed, and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your advance directive is legally valid. So that your advance directive 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 26506-9022.

16. *What if my doctor or my family does not agree with my treatment choices or health care decisions?*

You can prevent this from happening by talking with your family and health care providers about your decisions and personal values and beliefs. If others understand your choices and the reasons for them, there is less of a chance that they will challenge them later.

If you have made your wishes known in an advance directive and a disagreement does occur, your doctor and your representative must respect your wishes. You have a right to refuse or consent to health care. If your doctor cannot comply with your wishes, he or she must transfer your care to another doctor.

The consent or refusal of your medical power of attorney representative is as meaningful and valid as your own. The wishes of other family members will not override your own clearly expressed choices or those made by your representative on your behalf.

17. *Do I have to sign an advance directive to receive health care treatment?*

No. A doctor or other health care provider cannot require you to complete an advance directive as a condition for you to receive services.

18. *Will another state honor my advance directive?*

Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored.

19. *What if I change my mind about who I want to be my representative or about the kind of treatment I want?*

You should review your advance directive periodically to make sure it still reflects your wishes. The best way to change your advance directive is to create a new one. The new document will automatically cancel the old one. Be sure to notify all people who have copies of your advance directive that you completed a new one. Collect and destroy all copies of the old version. Send the new version to the e-Directive Registry so that your current one is available to treating health care providers.

Remember to submit your new advance directive 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 26506-9022.

20. *How can I be sure that the wishes expressed in my advance directive will be followed?*

Be sure your doctor has a current copy. Bring a copy with you if you are admitted to a health care facility. Tell people where you keep your advance directive. Fax or mail a copy of your advance directive to the WV e-Directive Registry at 844-616-1415 or 64 Medical Center Drive, PO Box 9022 Health Sciences North, Morgantown, WV 26506-9022, so that your wishes will be known in a medical emergency.

21. *What Special Directives or Limitations are inconsistent with the purpose of the Living Will? –*

Requests for CPR or breathing machines are inconsistent with the purpose of the living will and will be held to be invalid. West Virginia Code §16-30-4(g)

22. *Can I write my wishes for funeral arrangements on my advance directive?*

Yes, you can give the person you name as your medical power of attorney representative the authority to make decisions for you about funeral arrangements or cremation. The way to do so is to write instructions in the Special Directives or Limitations on this section of the medical power of attorney form or the combined medical power of attorney-living will form. To grant authority to your medical power of attorney representative, include a sentence as follows: "I authorize my representative to make decisions regarding my funeral arrangements or cremation."

23. *How can I get more copies of the advance directives forms and this booklet?*

You may call the **West Virginia Center for End-of-Life Care** toll-free at **1-877-209-8086**. If you have Internet access, go to www.wvendoflife.org and click on For Patients/Forms. You can print off forms from the website. You may also photo copy the forms in this booklet.

24. *Are there any advance directives in WV specifically related to mental/psychiatric health?*

Yes. The WV Mental Health Advance Directive (MHAD) is a legal advance directive that allows individuals with mental illness(es) to state their mental health treatment preferences in advance of a crisis. The MHAD provides a way to protect a person's autonomy and ability to self-direct care for treatment of mental health disorders similar to other advance directives used to direct care for medical disorders in palliative care and end-of-life care. For more information on the WV MHAD, please visit [Forms and Resources](#) link on our website and select MHAD.



West Virginia e-Directive Registry Sign-Up Form with Additional Required Demographic Information

In October 2010, West Virginia advance directive and medical order forms (DNR and POST) were changed to include more demographic information. West Virginia advance directives (Living Wills and Medical Powers of Attorney) and physician orders (DNR cards and POST forms) that do not include demographic information at the top of the form must have additional identifying information submitted in order to be added to the e-Directive Registry. With the patient's permission (or the medical power of attorney representative/surrogate's permission if the patient lacks capacity), fill in the information below and FAX or mail this form with a copy of **BOTH** sides of the advance directive and/or DNR card and/or POST form. Forms can also be uploaded from the Center's website at www.wvendoflife.org.

OPT-IN Indicate in the box to the left if you give permission as the person or as the guardian, medical power of attorney representative, or surrogate decision maker of the person to have the attached or previously submitted Living Will, Medical Power of Attorney, Combined Medical Power of Attorney and Living Will, Voluntary NonOpioid Advance Directive, POST form, and/or DNR card (if completed) included in the WV e-Directive registry and released to treating health care providers.

Please provide the following required information:

(Last Name/First/Middle Initial)

(Date of Birth)

(Address)

(City, State, Zip Code)

Sex (check one): (Male) (Female)

Last 4 numbers of your Social Security number: _____

Updating Demographic Information:

Please indicate in the box below if only updating demographic information. Please fax, upload, or mail a completed copy of this revised form.

Demographic updates for previously submitted advance directive forms to e-Directive Registry.

WV e-Directive Registry
64 Medical Center Drive,
PO Box 9022 Health Sciences North
Morgantown, WV 26506-9022
Phone: 877-209-8086
FAX: 844-616-1415

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
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, _____

(Insert your name and address)

hereby 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, 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).

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

_____ DATE _____

Signature of the Principal

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

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 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 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).

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

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. 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 or, to the best of my knowledge, under any will of the 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

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, _____

(Insert your name and address)

hereby 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 who 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