West Virginia Center for End-of-Life Care

Frequently Asked Questions about the Medical Power of Attorney

- ***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 healthcare decisions for you if you are unable to make them for yourself.

- ***What if I already have a living will? Do I need to create a medical power of attorney?***
  Most West Virginians complete 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 or decide not to do a living will.

- ***Can I still make my own healthcare decisions once I have created a medical power of attorney?***
  Yes. Your medical power of attorney does not become effective until you are not able to clearly say your own wishes.

- ***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.

- ***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 medical power of attorney periodically to make sure it still reflects your wishes. The best way to change your medical power of attorney 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 medical power of attorney 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.

- ***Do I need a lawyer to create a medical power of attorney?***
  No. A medical power of attorney can be completed without the assistance of a lawyer.

- ***Will another state honor my medical power of attorney?***
  Laws differ somewhat from state to state, but in general, a patient's expressed wishes will be honored

- ***What should I do with my medical power of attorney after I sign it?***
  After your medical power of attorney is signed, witnessed and notarized, keep the original document in a safe location where it can be easily found. A photo copy of your medical power of attorney is legally valid. You are encouraged to send a copy of your medical power of attorney to the West Virginia e-Directive Registry. See instructions below.

A complete listing of all Frequently Asked Questions relating to the Medical Power of Attorney can be found by clicking on the FAQS link on this page.

So that your medical power of attorney will 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, mailing a <u>copy</u> to the WV e-Directive Registry, 1195 Health Sciences North, Morgantown, WV 26506, or scanning and submitting it online at http://www.wvendoflife.org. The medical power of attorney on this site contains an Opt-In box. If you would like to have your medical power of attorney included in the Registry, you must INITIAL the box giving your permission.

Phone 877-209-8086 FAX: 844-616-1415 website: www.wvendoflife.org

Print Form

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: 844-616-1415

Last Name/First/Middle _____
Address _____
City/State/Zip _____
Date of Birth (mm/dd/yyyy) _____/_____/_____
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.

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

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 decision 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, 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 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: _____

_____
Notary Public