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** Initial 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, 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)

Gender (check one): ☐ (Male) ☐ (Female)

Last 4 numbers of your Social Security number: ____ ____ ____ ____

Updating Demographic Information:

Please initial 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
1195 Health Sciences North
P O Box 9022
Morgantown, WV 26506-9022
Phone: 877-209-8086
FAX: 844-616-1415

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

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
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 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 Date

_____

_____
Address

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

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: _____

_____
Signature of Notary Public

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
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.

_____ 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