

HB 3093 3

FILED

2007 APR -4 AM 11:20

OFFICE WEST VIRGINIA  
SECRETARY OF STATE

**WEST VIRGINIA LEGISLATURE**  
FIRST REGULAR SESSION, 2007



**ENROLLED**

**COMMITTEE SUBSTITUTE  
FOR  
House Bill No. 3093**

(By Delegate Perdue)



Passed March 10, 2007

In Effect Ninety Days from Passage

# ENROLLED

FILED

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COMMITTEE SUBSTITUTE

FOR

OFFICE WEST VIRGINIA  
SECRETARY OF STATE

## H. B. 3093

(BY DELEGATE PERDUE)

(Passed March 10, 2007; in effect ninety days from passage.)

AN ACT to amend and reenact §16-30-4 of the Code of West Virginia, 1931, as amended, relating to providing a form for a combined medical power of attorney and living will.

*Be it enacted by the Legislature of West Virginia:*

That §16-30-4 of the Code of West Virginia, 1931, as amended, be amended and reenacted to read as follows:

### **ARTICLE 30. WEST VIRGINIA HEALTH CARE DECISIONS ACT.**

#### **§16-30-4. Executing a living will or medical power of attorney or combined medical power of attorney and living will.**

- 1 (a) Any competent adult may execute at any time a living
- 2 will or medical power of attorney. A living will or medical
- 3 power of attorney made pursuant to this article shall be: (1)

4 In writing; (2) executed by the principal or by another person  
5 in the principal's presence at the principal's express direction  
6 if the principal is physically unable to do so; (3) dated; (4)  
7 signed in the presence of two or more witnesses at least  
8 eighteen years of age; and (5) signed and attested by such  
9 witnesses whose signatures and attestations shall be  
10 acknowledged before a notary public as provided in  
11 subsection (d) of this section.

12 (b) In addition, a witness may not be:

13 (1) The person who signed the living will or medical  
14 power of attorney on behalf of and at the direction of the  
15 principal;

16 (2) Related to the principal by blood or marriage;

17 (3) Entitled to any portion of the estate of the principal  
18 under any will of the principal or codicil thereto: *Provided,*  
19 That the validity of the living will or medical power of  
20 attorney shall not be affected when a witness at the time of  
21 witnessing such living will or medical power of attorney was  
22 unaware of being a named beneficiary of the principal's will;

23 (4) Directly financially responsible for principal's  
24 medical care;

25 (5) The attending physician; or

26 (6) The principal's medical power of attorney  
27 representative or successor medical power of attorney  
28 representative.

29 (c) The following persons may not serve as a medical  
30 power of attorney representative or successor medical power  
31 of attorney representative: (1) A treating health care provider  
32 of the principal; (2) an employee of a treating health care  
33 provider not related to the principal; (3) an operator of a  
34 health care facility serving the principal; or (4) any person  
35 who is an employee of an operator of a health care facility  
36 serving the principal and who is not related to the principal.

37 (d) It shall be the responsibility of the principal or his or  
38 her representative to provide for notification to his or her  
39 attending physician and other health care providers of the  
40 existence of the living will or medical power of attorney or a  
41 revocation of the living will or medical power of attorney.  
42 An attending physician or other health care provider, when  
43 presented with the living will or medical power of attorney,  
44 or the revocation of a living will or medical power of  
45 attorney, shall make the living will, medical power of  
46 attorney or a copy of either or a revocation of either a part of  
47 the principal's medical records.

48 (e) At the time of admission to any health care facility,  
49 each person shall be advised of the existence and availability  
50 of living will and medical power of attorney forms and shall  
51 be given assistance in completing such forms if the person  
52 desires: *Provided*, That under no circumstances may  
53 admission to a health care facility be predicated upon a  
54 person having completed either a medical power of attorney  
55 or living will.

56 (f) The provision of living will or medical power of  
57 attorney forms substantially in compliance with this article by  
58 health care providers, medical practitioners, social workers,  
59 social service agencies, senior citizens centers, hospitals,  
60 nursing homes, personal care homes, community care  
61 facilities or any other similar person or group, without  
62 separate compensation, does not constitute the unauthorized  
63 practice of law.

64 (g) The living will may, but need not, be in the following  
65 form and may include other specific directions not  
66 inconsistent with other provisions of this article. Should any  
67 of the other specific directions be held to be invalid, such  
68 invalidity shall not affect other directions of the living will  
69 which can be given effect without the invalid direction and to  
70 this end the directions in the living will are severable.

**The Kind of Medical Treatment I Want and Don't Want  
If I Have a Terminal Condition or  
Am In a Persistent Vegetative State**

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

75 I, \_\_\_\_\_, being of  
76 sound mind, willfully and voluntarily declare that I want my  
77 wishes to be respected if I am very sick and not able to  
78 communicate my wishes for myself. In the absence of my  
79 ability to give directions regarding the use of life-prolonging  
80 medical intervention, it is my desire that my dying shall not  
81 be prolonged under the following circumstances:

82 If I am very sick and not able to communicate my wishes  
83 for myself and I am certified by one physician, who has  
84 personally examined me, to have a terminal condition or to  
85 be in a persistent vegetative state (I am unconscious and am  
86 neither aware of my environment nor able to interact with  
87 others), I direct that life-prolonging medical intervention that  
88 would serve solely to prolong the dying process or maintain  
89 me in a persistent vegetative state be withheld or withdrawn.  
90 I want to be allowed to die naturally and only be given  
91 medications or other medical procedures necessary to keep  
92 me comfortable. I want to receive as much medication as is  
93 necessary to alleviate my pain.

94 I give the following SPECIAL DIRECTIVES OR  
95 LIMITATIONS: (Comments about tube feedings, breathing  
96 machines, cardiopulmonary resuscitation, dialysis and mental  
97 health treatment may be placed here. My failure to provide  
98 special directives or limitations does not mean that I want or  
99 refuse certain treatments.)

100

101

102

103

104 It is my intention that this living will be honored as the  
105 final expression of my legal right to refuse medical or  
106 surgical treatment and accept the consequences resulting  
107 from such refusal.

108 I understand the full import of this living will.

109  
110 Signed  
111

112  
113 Address

114 I did not sign the principal's signature above for or at the  
115 direction of the principal. I am at least eighteen years of age  
116 and am not related to the principal by blood or marriage,  
117 entitled to any portion of the estate of the principal to the best  
118 of my knowledge under any will of principal or codicil  
119 thereto, or directly financially responsible for principal's  
120 medical care. I am not the principal's attending physician or  
121 the principal's medical power of attorney representative or  
122 successor medical power of attorney representative under a  
123 medical power of attorney.

124  
125 Witness DATE  
126  
127  
128 Witness DATE

129 \_\_\_\_\_  
130 STATE OF

131 \_\_\_\_\_  
132 COUNTY OF

133 I, \_\_\_\_\_, a Notary Public of said  
134 County, do certify that \_\_\_\_\_, as  
135 principal, and \_\_\_\_\_ and \_\_\_\_\_, as  
136 witnesses, whose names are signed to the writing above  
137 bearing date on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
138 have this day acknowledged the same before me.

139 Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

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

141

142 Notary Public

143 (h) A medical power of attorney may, but need not, be in  
144 the following form, and may include other specific directions  
145 not inconsistent with other provisions of this article. Should  
146 any of the other specific directions be held to be invalid, such  
147 invalidity shall not affect other directions of the medical  
148 power of attorney which can be given effect without invalid  
149 direction and to this end the directions in the medical power  
150 of attorney are severable.

151 **STATE OF WEST VIRGINIA**  
152 **MEDICAL POWER OF ATTORNEY**

**The Person I Want to Make Health Care Decisions  
For Me When I Can't Make Them for Myself**

---

153 Dated: \_\_\_\_\_, 20\_\_\_\_\_

154 I, \_\_\_\_\_, hereby  
155 (Insert your name and address)

156 appoint as my representative to act on my behalf to give,  
157 withhold or withdraw informed consent to health care  
158 decisions in the event that I am not able to do so myself.

159 **The person I choose as my representative is:**

160

161 *(Insert the name, address, area code and telephone*  
162 *number of the person you wish to designate as your*  
163 *representative)*

164 **The person I choose as my successor representative is:**

165 If my representative is unable, unwilling or disqualified  
166 to serve, then I appoint:

167

168       *(Insert the name, address, area code and telephone*  
169 *number of the person you wish to designate as your*  
170 *successor representative)*

171       This appointment shall extend to, but not be limited to,  
172 health care decisions relating to medical treatment, surgical  
173 treatment, nursing care, medication, hospitalization, care and  
174 treatment in a nursing home or other facility, and home  
175 health care. The representative appointed by this document  
176 is specifically authorized to be granted access to my medical  
177 records and other health information and to act on my behalf  
178 to consent to, refuse or withdraw any and all medical  
179 treatment or diagnostic procedures, or autopsy if my  
180 representative determines that I, if able to do so, would  
181 consent to, refuse or withdraw such treatment or procedures.  
182 Such authority shall include, but not be limited to, decisions  
183 regarding the withholding or withdrawal of life-prolonging  
184 interventions.

185       I appoint this representative because I believe this person  
186 understands my wishes and values and will act to carry into  
187 effect the health care decisions that I would make if I were  
188 able to do so and because I also believe that this person will  
189 act in my best interest when my wishes are unknown. It is  
190 my intent that my family, my physician and all legal  
191 authorities be bound by the decisions that are made by the  
192 representative appointed by this document and it is my intent  
193 that these decisions should not be the subject of review by  
194 any health care provider or administrative or judicial agency.

195       It is my intent that this document be legally binding and  
196 effective and that this document be taken as a formal  
197 statement of my desire concerning the method by which any  
198 health care decisions should be made on my behalf during  
199 any period when I am unable to make such decisions.

200       In exercising the authority under this medical power of  
201 attorney, my representative shall act consistently with my  
202 special directives or limitations as stated below.



203 I am giving the following SPECIAL DIRECTIVES OR  
204 LIMITATIONS ON THIS POWER: (Comments about tube  
205 feedings, breathing machines, cardiopulmonary resuscitation,  
206 dialysis, funeral arrangements, autopsy and organ donation  
207 may be placed here. My failure to provide special directives  
208 or limitations does not mean that I want or refuse certain  
209 treatments.)  
210  
211

212 THIS MEDICAL POWER OF ATTORNEY SHALL  
213 BECOME EFFECTIVE ONLY UPON MY INCAPACITY  
214 TO GIVE, WITHHOLD OR WITHDRAW INFORMED  
215 CONSENT TO MY OWN MEDICAL CARE.  
216  
217 Signature of the Principal

218 I did not sign the principal's signature above. I am at  
219 least eighteen years of age and am not related to the principal  
220 by blood or marriage. I am not entitled to any portion of the  
221 estate of the principal or to the best of my knowledge under  
222 any will of the principal or codicil thereto, or legally  
223 responsible for the costs of the principal's medical or other  
224 care. I am not the principal's attending physician, nor am I  
225 the representative or successor representative of the principal.  
226

227 Witness: DATE  
228  
229  
230 Witness: DATE

231  
232 STATE OF

233  
234 COUNTY OF

235 I, \_\_\_\_\_, a Notary Public of said  
236 County, do certify that \_\_\_\_\_, as  
237 principal, and \_\_\_\_\_ and \_\_\_\_\_, as  
238 witnesses, whose names are signed to the writing above

239 bearing date on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
240 have this day acknowledged the same before me.

241 Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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

243 \_\_\_\_\_

244 Notary Public

245 (i) A combined medical power of attorney and living will  
246 may, but need not, be in the following form, and may include  
247 other specific directions not inconsistent with other  
248 provisions of this article. Should any of the other specific  
249 directions be held to be invalid, such invalidity does not  
250 affect other directions of the combined medical power of  
251 attorney and living will which can be given effect without  
252 invalid direction and to this end the directions in the  
253 combined medical power of attorney and living will are  
254 severable.

255 **STATE OF WEST VIRGINIA**  
256 **COMBINED MEDICAL POWER OF ATTORNEY**  
257 **AND LIVING WILL**

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**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**

258 Dated: \_\_\_\_\_, 20\_\_\_\_

259 I, \_\_\_\_\_, hereby

260 *(Insert your name and address)*

261 appoint as my representative to act on my behalf to give,  
262 withhold or withdraw informed consent to health care  
263 decisions in the event that I am not able to do so myself.

264 The person I choose as my representative is:

265

266 *(Insert the name, address, area code and telephone number*  
267 *of the person you wish to designate as your representative).*

268 If my representative is unable, unwilling or disqualified  
269 to serve, then I appoint as my successor representative:  
270  
271 *—*  
272 *(Insert the name, address, area code and telephone number*  
273 *of the person you wish to designate as your successor*  
*representative).*

274 This appointment shall extend to, but not be limited to,  
275 health care decisions relating to medical treatment, surgical  
276 treatment, nursing care, medication, hospitalization, care and  
277 treatment in a nursing home or other facility, and home  
278 health care. The representative appointed by this document  
279 is specifically authorized to be granted access to my medical  
280 records and other health information and to act on my behalf  
281 to consent to, refuse or withdraw any and all medical  
282 treatment or diagnostic procedures, or autopsy if my  
283 representative determines that I, if able to do so, would  
284 consent to, refuse or withdraw such treatment or procedures.  
285 Such authority shall include, but not be limited to, decisions  
286 regarding the withholding or withdrawal of life-prolonging  
287 interventions.

288 I appoint this representative because I believe this person  
289 understands my wishes and values and will act to carry into  
290 effect the health care decisions that I would make if I were  
291 able to do so, and because I also believe that this person will  
292 act in my best interest when my wishes are unknown. It is  
293 my intent that my family, my physician and all legal  
294 authorities be bound by the decisions that are made by the  
295 representative appointed by this document, and it is my intent  
296 that these decisions should not be the subject of review by  
297 any health care provider or administrative or judicial agency.

298 It is my intent that this document be legally binding and  
299 effective and that this document be taken as a formal  
300 statement of my desire concerning the method by which any  
301 health care decisions should be made on my behalf during  
302 any period when I am unable to make such decisions.

303 In exercising the authority under this medical power of  
304 attorney, my representative shall act consistently with my  
305 special directives or limitations as stated below.

306 I am giving the following SPECIAL DIRECTIVES OR  
307 LIMITATIONS ON THIS POWER: (Comments about tube  
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309 dialysis, mental health treatment, funeral arrangements,  
310 autopsy, and organ donation may be placed here. My failure  
311 to provide special directives or limitations does not mean that  
312 I want or refuse certain treatments).

313 1. If I am very sick and not able to communicate my  
314 wishes for myself and I am certified by one physician who  
315 has personally examined me, to have a terminal condition or  
316 to be in a persistent vegetative state (I am unconscious and  
317 am neither aware of my environment nor able to interact with  
318 others,) I direct that life-prolonging medical intervention that  
319 would serve solely to prolong the dying process or maintain  
320 me in a persistent vegetative state be withheld or withdrawn.  
321 I want to be allowed to die naturally and only be given  
322 medications or other medical procedures necessary to keep  
323 me comfortable. I want to receive as much medication as is  
324 necessary to alleviate my pain.

325 2. Other directives: \_\_\_\_\_  
326  
327  
328  
329

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

334  
335 Signature of the Principal

336 I did not sign the principal's signature above. I am at least  
337 eighteen years of age and am not related to the principal by  
338 blood or marriage. I am not entitled to any portion of the  
339 estate of the principal or to the best of my knowledge under  
340 any will of the principal or codicil thereto, or legally  
341 responsible for the costs of the principal's medical or other  
342 care. I am not the principal's attending physician, nor am I  
343 the representative or successor representative of the principal.

344 Witness \_\_\_\_\_ DATE \_\_\_\_\_  
345 Witness \_\_\_\_\_ DATE \_\_\_\_\_  
346 STATE OF \_\_\_\_\_  
347 COUNTY OF \_\_\_\_\_

348 I, \_\_\_\_\_, a Notary Public of said  
349 county, do certify that \_\_\_\_\_, as principal,  
350 and \_\_\_\_\_ and \_\_\_\_\_,  
351 as witnesses, whose names are signed to the writing above  
352 bearing date on the \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_,  
353 have this day acknowledged the same before me.

354 Given under my hand this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_.

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

356 \_\_\_\_\_  
357 Signature of Notary Public

That Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.


  
\_\_\_\_\_  
Chairman Senate Committee

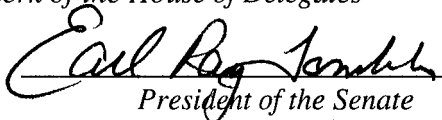
  
\_\_\_\_\_  
Chairman House Committee

Originating in the House

In effect ninety days from passage.

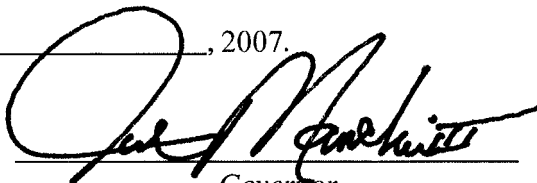
  
\_\_\_\_\_  
Clerk of the Senate

  
\_\_\_\_\_  
Clerk of the House of Delegates

  
\_\_\_\_\_  
President of the Senate

  
\_\_\_\_\_  
Speaker of the House of Delegates

The within is approved this the 2<sup>nd</sup>  
day of April, 2007.

  
\_\_\_\_\_  
Governor

PRESENTED TO THE  
GOVERNOR

MAR 26 2007

Time

*4:00pm*