HB 3093 S

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

COMMITTEE SUBSTITUTE

FOR

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.

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

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

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

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

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

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

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

(5) The attending physician; or

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

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

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

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

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

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

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

Address

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:_____

Notary Public

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

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

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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.

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, 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.

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:_____

_____

Notary Public

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

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*).

If my representative is unable, unwilling or disqualified to serve, then I appoint as my successor representative:

_____

(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.

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

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

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 2nd day of April, 2007.

Governor