WEST VIRGINIA MEDICAL POWE

THE PERSON I WANT TO MAKE HEALTH CARE DEC
T MAKE THEM FOR MYSE

Dated this _____ day of _____, _

I, **Bhaskar Mitra** , of address , City , West Virginia , hereb
of safasfasf, , safasf, , Alabama, 50000, (Tel: 5564654
my behalf to give, withhold or withdraw informed consent to health
able to do so myself .

If my representative is unable, unwilling or disqualified to serve,
, of asfasf, , safasfdsfgbvfc, , Alaska, 51000, (Tel: 6545
for health care decisions.

This appointment shall extend to, but not be limited to, health care
surgical treatment, nursing care, medication, hospitalization, care a
facility, and home health care. The representative appointed by thi
act on my behalf to consent to, refuse or withdraw any and all me
or autopsy if my representative determines that I, if able to do so, w
treatment or procedures. Such authority shall include, but not
withholding or withdrawal of life-prolonging interventions.

I appoint this representative because I believe this person understan
carry into effect the health care decisions that I would make if I
believe that this person will act in my best interests when my wish
family, my physician and all legal authorities be bound by the deci
appointed by this document, and it is my intent that these decisions
any health care provider, or administrative or judicial agency.

It is my intent that this document be legally binding and effectiv
formal statement of my desire concerning the method by which any
my behalf during any period when I am unable to make such decisio

In exercising the authority under this medical power of attorney, I with my special directives or limitations as stated below.

I am giving the following SPECIAL DIRECTIVES OR LIMITAT
about tube feedings, breathing machines, cardiopulmonary resusc
autopsy and organ donation may be placed here. My failure to provi
not mean that I want or refuse certain treatments).

1. If I am very sick and not able to communicate my wishes for my
who has personally examined me, to have a terminal condition or to
unconscious and am neither aware of my environment nor able to
prolonging medical intervention that would serve solely to prolong
persistent vegetative state be withheld or withdrawn. I want to be all
medications or other medical procedures necessary to keep me c
medication as is necessary to alleviate my pain.

2. Other directives:

_____

_____

_____

(Add additional sheets if necessary.)

My representative has the full and immediate power and authority
extent I could do so individually, any information, verbal or written,
including, but not limited to, my individually identifiable health inf
release authority applies to any information governed by t
Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45
physician, health care professional, dentist, health plan, hospital,
covered health care provider, any insurance company, and the Me
health care clearinghouse that has provided treatment or services t
payment from me for such services, to give, disclose, and release t
all of my individually identifiable health information and medical
future medical or mental health condition. This authority given my
agreement which I may have made with my health care providers
individually identifiable health information. This authority given
immediately, has no expiration date and shall expire only in the eve
and deliver it to my health care provider.

THIS MEDICAL POWER OF ATTORNEY SHALL BECOM
INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INF
MEDICAL CARE.

SIGNATURE AND ACKNOWLEDG

Signature: _____
Bhaskar Mitra

DECLARATION OF WITNES

I did not sign the principal's signature above. I am at least eighteen y
principal by blood or marriage. I am not entitled to any portion of the
my knowledge under any will of the principal or codicil thereto, or le
principal's medical or other care. I am not the principal's attending p
successor representative of the principal.

WITNESS 1: _____ Dated: _____
[signature]

_____ _____

[name printed] [street a

[city, sta

WITNESS 2: _____ Dated: _____
[signature]

_____ _____

[name printed] [street a

[city, sta

STATE OF WEST VIRGINIA)
) ss.
COUNTY OF _____)

I, the undersigned, a Notary Public of said County, do certify that _____ and _____, as witnesse bearing date on the ____ day of _____have this day acknowledged the sa

Given under my hand this _____ day of _____.

_____

NOTARY PUBLIC

My Commission ex

WEST VIRGINIA LIVING

THE KIND OF MEDICAL TREATMENT I WANT AND DON'
CONDITION OR AM IN A PERSISTENT VE

LIVING WILL made this day of , .

I, **Bhaskar Mitra** , being of sound mind, willfully and voluntaril
respected if I am very sick and not able to communicate my wishes
to give directions regarding the use of life-prolonging medical inte
shall not be prolonged under the following circumstances:

If I am very sick and not able to communicate my wishes for mys
who has personally examined me, to have a terminal condition or to
unconscious and am neither aware of my environment nor able to
prolonging medical intervention that would serve solely to prolong
persistent vegetative state be withheld or withdrawn. I want to be al
medications or other medical procedures necessary to keep me c
medication as is necessary to alleviate my pain.

I give the following SPECIAL DIRECTIVES OR LIMITATIO
breathing machines, cardiopulmonary resuscitation, dialysis, and
here. My failure to provide special directives or limitations does
treatments.)

_____

_____

_____

(Add additional sheets if needed.)

It is my intention that this living will be honored as the final expressi
or surgical treatment and accept the consequences resulting from suc

I understand the full import of this living will

Signature: _____ Date: ____

Bhaskar Mitra

My Address: address , City , West Virginia

DECLARATION OF WITNES

I did not sign the principal's signature above. I am at least eighteen
principal by blood or marriage. I am not entitled to any portion of th
my knowledge under any will of the principal or codicil thereto, or
principal's medical or other care. I am not the principal's attending
successor representative of the principal.

WITNESS 1: _____ Dated: _____
[signature]

_____ _____
[name printed] [street

_____
[city, st

WITNESS 2: _____ Dated: _____
[signature]

_____ _____

[name printed] [street a

[city, sta

STATE OF WEST VIRGINIA)
) ss.
COUNTY OF _____)

I, the undersigned, a Notary Public of said County, do certify that _____ and _____, as witnesse bearing date on the ____ day of have this day acknowledged the same before me.

Given under my hand this _____ day of _____.

_____
NOTARY PUBLIC

My Commission ex