Part I: Power of Attorney for Health Care

PRINT YOUR NAME

I, _____,

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ATTORNEY IN FACT

appoint _____,

whose address is _____,

and whose telephone number is _____,
as my attorney in fact for health care.

If my first choice is unable, unwilling, or not reasonably available to act

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE ATTORNEY IN FACT

as my attorney in fact I appoint _____,

whose address is _____,

and whose telephone number is _____,
as my successor attorney in fact for health care

I authorize my attorney in fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions, including decisions to withhold or withdraw life-sustaining treatment and artificially administered nutrition and hydration. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

When making health care decisions for me, my attorney in fact should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this advance directive or other legal or nonlegal document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care attorney in fact should make decisions for me that my health care attorney in fact believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

NEBRASKA ADVANCE DIRECTIVE – PAGE 2 OF 7

STATE YOUR DIRECTIONS FOR THE USE OF LIFE-SUSTAINING TREATMENT, IF ANY

STATE YOUR DIRECTIONS FOR THE USE OF ARTIFICIAL NUTRITION AND HYDRATION, IF ANY

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Further Instructions. Attach additional pages as needed.

I direct that my attorney in fact comply with the following instructions on life-sustaining treatment: (optional)

_____
_____
_____

I direct that my attorney in fact comply with the following on artificially administered nutrition and hydration: (optional)

_____
_____
_____
_____

I direct that my power of attorney comply with the following instructions or limitations: (optional)

_____
_____
_____
_____
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_____
_____
_____

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY POWER OF ATTORNEY, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Part II: Declaration Relating to the Use of Life-Sustaining Treatment

If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to:

INITIAL YOUR PREFERENCE IN THE EVENT YOU ARE IN A TERMINAL CONDITION

INITIAL ONLY ONE PREFERENCE

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available life-sustaining treatment or other medical interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

Any questions regarding how to interpret or apply my declaration shall be resolved by my attorney in fact appointed under a durable power of attorney for health care (Part I), if I have appointed one.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

I further direct that:

Attach additional pages if needed.

PART III: EXECUTION

This Health Care Directive will not be valid unless it is EITHER:

IF YOU CHOOSE TO SIGN WITH WITNESSES, USE ALTERNATIVE 1, BELOW

(A) Signed by two (2) adult witnesses who are present when you sign or acknowledge your signature.

Only one witness may be an administrator or employee of a health care provider who is providing treatment. Neither witness may be an employee of your health or life insurer.

If you have filled out Part I, the power of attorney for health care, your witnesses may not be your spouse, parent, child, grandchild, sibling, your presumptive heir, any known devisee (someone who you have named in your will to inherit from your estate), your attending physician, or your attorney in fact or his/her alternate. (Use Alternative 1, below (page), if you decide to have your signature witnessed.)

OR

IF YOU CHOOSE TO HAVE YOUR SIGNATURE NOTARIZED, USE ALTERNATIVE 2, BELOW

(B) Witnessed by a notary.

If you have filled out Part I, the power of attorney for health care, your document may not be notarized by your attorney in fact or his/her alternate. (Use Alternative 2, below (page), if you decide to have your signature notarized.)

Alternative No. 1: Sign Before Witnesses

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

PRINT YOUR NAME

_____
(printed name)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witness No. 1

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Witness No. 2

_____ _____
(signature of witness) (date)

_____
(printed name of witness)

Alternative No. 2: Sign Before a Notary Public

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

PRINT YOUR NAME

_____
(printed name)

A NOTARY PUBLIC SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

State of Nebraska,)
) ss.
County of _____)

On this _____ day of _____ 20_____, before me,

_____, a notary public in

_____ County, personally

came_____,
personally to known to be the identical person whose name is affixed to the above advance directive as principal of power of attorney for health care, if Part I is filled out, and/or as declarant of declaration relating to the use of life-sustaining treatment, if Part II is filled out, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated in Part I, if it has been completed.

Witness my hand and notarial seal at _____
in such county the day and year last above written.

SEAL

_____
signature of notary public

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898