Nevada Durable POWER of ATTORNEY for

WARNING

TO PERSONS

EXECUTING THIS

DOCUMENT:

THIS IS AN IMPORTANT

LEGAL DOCUMENT.

IT CREATES A DURABLE

POWER OF ATTORNEY

FOR HEALTH CARE.

BEFORE EXECUTING

THIS DOCUMENT, YOU

SHOULD KNOW THESE

IMPORTANT FACTS:

1. This document gives the person you designate as your *attorney-in-fact* the power to make health care decisions for you. This Durable Power of Attorney for Health Care is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any type/s of treatment or placement that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.

3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this power will exist indefinitely from the date you execute this document and, if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

HEALTH CARE DECISIONS

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.

8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for Health Care.

10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you

THE PATIENT'S RIGHT TO DECIDE

All adult individuals in hospitals, nursing homes,and other health care facilities have certain rights. Under the Patient Self-Determination Act, health care facilities are required to inform you of your rights as a patient and of their policies.

Each adult individual has the right to prepare legal documents known as "Advance Directives." These documents allow you to state in advance what kinds of treatment you want or do not want under medical circumstances that would prevent you from communicating your wishes to your doctor.

We strongly encourage everyone to exercise their right to make choices surrounding the issues of dying and be mindful of their ability and responsibility to transform death into a subject openly discussed by all.

1. DESIGNATION of HEALTH CARE AGENT

I, *(insert your name)*, _____

do hereby designate and appoint:

Name _____

Address _____

Phone (____) _____ Work (____) _____ ext ___
as my attorney-in-fact to make health care decisions for me as authorized in this document.

Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact:

(1) *your treating provider of health care;*
(2) *an employee of your treating provider of health care;*
(3) *an operator of a health care facility, or;*
(4) *an employee of an operator of a health care facility.*

2. CREATION of DURABLE POWER of ATTORNEY for HEALTH CARE

By this document I intend to create a Durable Power of Attorney for Health Care by appointing the person designated above to make health care decisions for me. This Durable Power of Attorney for Health Care shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT of AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraphs 4 or 6.

4. SPECIAL PROVISIONS and LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health

treatment facility, convulsive treatment, psycho surgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for Health Care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

5. DURATION

I understand that this Durable Power of Attorney for Health Care will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Durable Power of Attorney for Health Care end on:

_____ , 20 ___.

6. STATEMENT of DESIRES

a) With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space on the following page.

IF THE STATEMENT *REFLECTS YOUR DESIRES,*
INITIAL THE BOX NEXT TO THE STATEMENT

☐ **(1)** I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.

☐ **(2)** If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)*

☐ **(3)** If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)*

☐ **(4)** Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld.

☐ **(5)** I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

MY MEMORIAL SERVICE

If there is to be a memorial service for me, I wish for this service to include the following *(list music, songs, readings or other specific requests that you have):*

Add other wishes here *(such as your wishes about donating any or all parts of your body when you die):*

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

6. STATEMENT of DESIRES ***(continued)***

b) It is my intention that this instrument serve both as a self-executing document and as a delegation of power to my attorney-in-fact. This document shall be deemed an exercise of all rights that I may have under the United States Constitution, the Constitution of Nevada, and any other relevant state and federal laws, rules, regulations and decisions, to refuse medical treatment.

c) I desire that my wishes be carried out through the authority given to my attorney-in-fact by this document despite any contrary feelings, beliefs or opinions of other members of my family, relatives or friends.

d) I realize that the situations described in this document are subject to various interpretations, and I am confident that the person(s) named as my attorney-in-fact will exercise the judgment that I myself would exercise if competent.

e) If my attorney-in-fact or my alternate attorney(s) in fact is unavailable, I nevertheless request that my instructions and preferences in this document be observed.

7. DESIGNATION of ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 4, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-fact

Name _____

Address _____

Phone (___) _____ Work (____) _____ ext ____

B. Second Alternative Attorney-in-fact

Name _____

Address _____

Phone (___) _____ Work (____) _____ ext ____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care. However, this shall not be construed as a revocation of any durable power of attorney I may have made for the management of my business and/or personal affairs.

9. WAIVER of CONFLICT of INTEREST

If my designated attorney-in-fact or if any alternate designated attorney-in-fact is my spouse or is one of my children then in that event I waive any conflict of interest that said spouse or child may have in carrying out the provisions of this Durable Power of Attorney for Health Care, by reason of the fact that said spouse or child may be a recipient of my estate whether by Will, the laws of intestate succession or pursuant to a Trust or other arrangement.

(You must DATE and SIGN this Durable POWER of ATTORNEY for Health Care)

I sign my name to this Durable Power of Attorney for Health Care on:

_____ , 20 _____,
(date)

at _____
(city and state)

Signature _____

Name _____

Address _____

Phone (___) _____ Work (____) _____ ext ____

Social Security Number _____

(This Durable Power of Attorney for Health Care will not be valid for making health care decisions unless it is either **(1)** *signed by at least two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature, or* **(2)** *acknowledged before a notary public.)*

10. CERTIFICATE of ACKNOWLEDGMENT of NOTARY PUBLIC

STATE OF NEVADA)
) ss.
COUNTY OF)

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

_____, *(here insert name of Notary Public)*

personally appeared _____ ,

(here insert name of principal) personally known to me *(or proved to me on the basis of satisfactory evidence)* to be the person who executed the above instrument, and acknowledged to me that he or she executed the same for purposes stated therein. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
NOTARY PUBLIC

11. STATEMENT of WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: **(1)** *a person you designate as the attorney-in-fact,* **(2)** *a provider of health care,* **(3)** *an employee of a provider of health care,* **(4)** *the operator of a health care facility, or* **(5)** *an employee of an operator of a health care facility.*

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community health care facility, nor an employee of a health care facility.

Signature _____

Print Name _____

Residence Address _____

Date _____ , 20 _____

Signature _____

Print Name _____

Residence Address _____

Date _____ , 20 _____

NOTE: AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION

12. DECLARATION of WITNESS

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature _____

Print Name _____

Residence Address _____

Date _____ , 20 _____

Signature _____

Print Name _____

Residence Address _____

Date _____ , 20 _____

COPIES: *You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.*

DECLARATION/LIVING WILL

If I should 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 any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

NOTE: *if you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:*

☐

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld pursuant to this declaration.

NOTICE

Make sure your loved ones can find this document. Make copies for all concerned and make sure they understand its importance.

Signed this _____ day of _____, 20 ____ .

Signature _____

Address _____

The declarant voluntarily signed this document in my presence.

Witness _____

Address _____

Witness _____

Address _____

A letter to my loved ones. . .

Dear Loved Ones,

I want the best quality of life possible during my last days. Therefore, I hereby request as follows....

☐	(a)	I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering possible. Please consult with my doctor in this regard.
☐	(b)	If my temperature is above normal, I want a cool moist cloth put on my head.
☐	(c)	I want my mouth and lips kept moist.
☐	(d)	I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.
☐	(e)	I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide my comfort.
☐	(f)	I want my personal care such as nail clipping, hair combing, teeth brushing, and shaving as long as they do not cause me pain.

Principal _____

I hope my family and friends would consider that . . .

☐	(a)	I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.
☐	(b)	Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.
☐	(c)	Please don't be afraid to hold my hand or hug me.
☐	(d)	Please tell the members of my church or synagogue I am sick and ask them to pray and visit me.
☐	(e)	Please maintain a cheerful atmosphere around me.
☐	(f)	Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.
☐	(g)	My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.
☐	(h)	If at all possible, allow me to die in my home.
☐	(i)	Please arrange for me to watch on television, or listen to my favorite sports events.
☐	(j)	Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.
☐	(k)	I want to have my favorite types of music played when possible.
☐	(l)	I want to have religious readings read to me when I am near death.
☐	(m)	I want to have my favorite poems read to me from time to time.

Principal _____

I want you to know the following about my thoughts and conerns if I am disabled and cannot convey these thoughts to you verbally. . .

(1) I want you to know that I love you. ☐

(2) I would like to be forgiven for the times I have hurt you. ☐

(3) I forgive you for what you may done to me in my life. ☐

(4) I want you to know that I do not fear death itself. ☐

(5) I want all of my family members to recommit their love for one another. ☐

(6) Please remember me the way I was before I had a terminal illness. ☐

(7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all. ☐

(8) Don't be afraid to seek counseling, if you have trouble with my death. ☐

If friends want to know how I want to be remembered tell them the following. . .

The following person(s) know my funeral plans...

At any memorial service for me, I want to include the following music, songs, redings or other plans for such a service. . .

I also have the following requests . . .

These are requests of my family members, loved ones, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this _____ day of _____, 20 ____

*Signature*_____

*Print Name*_____

For additional information, please contact:
The Nevada Center for Ethics & Health Policy
University of Nevada, Reno/339 – Reno NV. 89557-0133
www.unr.edu/ncehp
www.HealthEthics.org
RENO *Tel. (775) 327-2309 Fax (775) 327-2203*
LAS VEGAS/Southern Nevada *Tel. (702) 257-5594*

Revised 4/07, *MS Word*

Principal _____

EMERGENCY MEDICAL NOTICE:
Advance Directive on file

Please check with these agents for a copy of my Advance Directive:

1. PRIMARY AGENT NAME _____

Work (____) _____ Home (____) _____

Cell (____) _____ Other (____) _____

2. 1st ALTERNATE AGENT NAME _____

Work (____) _____ Home (____) _____

Cell (____) _____ Other (____) _____

2. 2nd ALTERNATE AGENT NAME _____

Work (____) _____ Home (____) _____

Cell (____) _____ Other (____) _____

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Please check with these agents for a copy of my Advance Directive:

1. PRIMARY AGENT NAME _____

Work (____) _____ Home (____) _____

Cell (____) _____ Other (____) _____

2. 1st ALTERNATE AGENT NAME _____

Work (____) _____ Home (____) _____

Cell (____) _____ Other (____) _____

2. 2nd ALTERNATE AGENT NAME _____

Work (____) _____ Home (____) _____

Cell (____) _____ Other (____) _____

NOTICE: remove wallet card, fill out, and carry with your identification; second card is an extra.

EMERGENCY MEDICAL NOTICE:
Advance Directive on file

SEE INSIDE

www.HealthEthics.org

Nevada Center for Ethics & Health Policy
University of Nevada, Reno •• Mailstop 339 •• Reno NV 89557-0133
(775) 327-2309 •• Fax: (775) 327-2203 •• www.unr.edu/ncehp

I *(name)* _____ have executed a DURABLE POWER OF ATTORNEY FOR HEALTH CARE pursuant to Nevada Civil Code NRS 449.830-449.860. If I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card who has a copy of my Durable Power of Attorney should be contacted immediately in the order listed.

EMERGENCY MEDICAL NOTICE:
Advance Directive on file

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EMERGENCY MEDICAL NOTICE:
Advance Directive on file

I *(name)* _____ have executed a DURABLE POWER OF ATTORNEY FOR HEALTH CARE pursuant to Nevada Civil Code NRS 449.830-449.860. If I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card who has a copy of my Durable Power of Attorney should be contacted immediately in the order listed.

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