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 ____

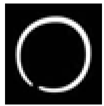
The declarant voluntarily signed this document in my presence.

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.

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.

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...

Principal _____

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 friends, 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*

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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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*

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.

SEE INSIDE

EMERGENCY MEDICAL NOTICE: *Advance Directive on file*

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www.HealthEthics.org

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