Power of Attorney For Health Care

I appoint,_____, whose address is _____, and whose telephone number is (____) _____, as my attorney-in fact for health care. I appoint _____, whose address is _____, 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 heath care decisions for me when I am determined to be incapable of making my own health care decisions.

I direct that my attorney-in-fact comply with the following instructions or limitations:

_____

_____

_____

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

_____

_____

_____

I instruct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:

_____

_____

_____

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 ATTONREY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY-IN-FACT, 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 HEATLH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Dated this ____ day of _____, 20_____

_____

Signature of Principal

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, and that (he/she) signed (his/her) signature on this power of attorney for health care in our presence; that (he/she) 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.

Witnessed By:

_____ _____
(Signature of Witness) (Printed Name of Witness)

_____
(Address)

_____ _____
(Date)

_____ _____
(Signature of Witness) (Printed Name of Witness)

_____
(Address)

_____ _____
(Date)

OR

State of Nebraska)
)ss
County Of _____)

On this _____day of _____, 20_____, before me, a notary public in and for the State of Nebraska, personally to me known to be the identical person whose name is affixed to the above power of attorney for heath care as principal, 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 by this power of attorney for health care.

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

_____
Notary Public

LIVING WILL DECLARATION

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 withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

You may list specific life sustaining treatments you do not want such as cardiac resuscitation, mechanical respiration (i.e. breathing machine) and artificial feeding/fluids by tube. Otherwise, your general statement, above, will stand for your wishes.

I especially **do not want**: _____

_____

_____

You may want to add instructions or care you **do want** – for example, pain medication; or that you prefer to die at home, if possible.

Other instructions/comments_____

_____

_____ _____

Signature Date

_____

Address City State

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC

The declarant voluntarily signed this writing in my presence.

Witnessed by: _____ _____

Address

Date _____ _____

City/State

Witnessed by: _____ _____

Address

Date _____ _____

City/State

--- OR---

STATE OF NEBRASKA)
)ss.
COUNTY of _____)

The declarant voluntarily signed this document in my presence on this _____day of _____, 20____.

_____

Notary Public