

**NEVADA**  
**Advance Directive**  
**Planning for Important Healthcare Decisions**

***Caring Connections***  
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*800/658-8898*

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

**It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

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## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

## Introduction to Your Nevada Advance Directive

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Nevada Durable Power of Attorney for Healthcare Decisions** lets you name someone to make decisions about your healthcare—including decisions about life support—if you can no longer speak for yourself. The Durable Power of Attorney for Healthcare Decisions is especially useful because it appoints someone to speak for you any time you are unable to make your own healthcare decisions, not only at the end of life. It goes into effect when signed, unless you indicate in the Durable Power of Attorney for Healthcare that you want it to become effective at a future date or when should become effective when you become incapacitated, it becomes effective upon a determination in writing by a physician, psychiatrist or licensed psychologist that you are incapacitated.

2. The **Nevada Declaration** is your state's living will. It lets you state your wishes about the withholding or withdrawal of life-sustaining treatment when you have an incurable or irreversible condition that, in your physician's opinion, will cause your death within a relatively short time if you are unable to make decisions regarding your medical care. It is a good idea to designate your agent as the person to make decisions about the withholding or withdrawal of treatment in your Declaration. You also can allow your treating physician to make the decision if your agent is unable or unwilling to service. Any instructions you include in your Declaration should be consistent the instructions you provide in your Durable Power of Attorney for Healthcare.

Following the Nevada Declaration is a form you may use if you wish to donate your organs following your death.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## **Instructions for Completing Your Nevada Durable Power of Attorney for Healthcare Decisions**

An agent is a person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself.

### **Whom should I appoint as my agent?**

Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you. Unless he or she is your spouse, legal guardian or next of kin, the person you appoint as your agent **cannot** be:

- your healthcare provider,
- an employee of your healthcare provider,
- an operator of a healthcare facility, or
- an employee of a healthcare facility.

You can appoint two or more persons to act as co-agents. Unless you provide otherwise, each co-agent will be able to exercise authority independently. You also may appoint one or more successor agents who step in if the person you name as agent is unable, unwilling or unavailable to act for you.

### **How do I make my Nevada Durable Power of Attorney for Healthcare Decisions legal?**

The law requires that you have your Durable Power of Attorney for Healthcare witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public, or
2. Sign your document in the presence of two witnesses, who must also sign the document to show that they personally know you and believe you to be of sound mind and under no duress, fraud, or undue influence, that you signed or acknowledged the Durable Power of Attorney in their presence, and that they do not fall into any of the categories of people who cannot be witnesses. These witnesses cannot be:

- the person you name as your agent,
- a healthcare provider,
- an employee of a healthcare provider,
- an operator of a healthcare facility, or
- an employee of an operator of a healthcare facility.

Note: At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or by operation of law.

## **Instructions for Completing Your Nevada Durable Power of Attorney for HealthCare Decisions (continued)**

### **Should I add personal instructions to my Nevada Durable Power of Attorney for Healthcare Decisions?**

By Nevada law, your agent must make decisions concerning the use or non-use of life-sustaining treatment which conform to your desires to the extent your desires are known by your agent. Talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life." The enclosed document lists statements on page 5 about withholding or withdrawing life-sustaining treatment. Read each statement carefully and initial only those statements that reflect your desires. Do not edit or cross out language that does not reflect your desires. These instructions should be consistent with any included in your Declaration.

There also is space on page 5 of the enclosed document for you to add any other statements regarding your desired medical care. One of the strongest reasons for naming an attorney-in-fact is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add further instructions, you might unintentionally restrict your agent's power to act in your best interest.

### **What if I change my mind?**

You may revoke the appointment of your agent at any time by notifying your agent in writing or orally. You also may revoke your agent's authority to make healthcare decisions for you by notifying your treating physician, hospitals, or other healthcare provider orally or in writing. Your Durable Power of Attorney is automatically revoked if:

- you execute a new Durable Power of Attorney, or
- you appoint your spouse as your agent and your marriage ends.

If you wish to set an expiration date for your Durable Power of Attorney, you may do so on page 4, section 5. If you do not set an expiration date, your Durable Power of Attorney remains valid indefinitely, unless you revoke it.

## **Instructions for Completing Your Nevada Durable Power of Attorney for Healthcare Decisions (continued)**

### **What other important facts should I know?**

Due to restrictions in Nevada law, your agent does not have the power to authorize any of the following:

- Abortion
- Sterilization
- Commitment or placement in a facility for treatment of mental illness
- Convulsive treatment
- Psychosurgery
- Aversive intervention
- Experimental, biomedical or behavioral treatment, or participation in any medical, biomedical or behavioral research program
- Any other treatment which you, in your Durable Power of Attorney for Health Care, state that the agent may not consent to

## **Instructions for Completing Your Nevada Declaration**

### **How do I make my Nevada Declaration legal?**

The law requires that you sign your Declaration in the presence of two adult witnesses of sound mind, who must also sign the document to show that you voluntarily signed the document in their presence or acknowledge it before a notary public.

### **Can I add personal instructions to my Declaration?**

No. The Nevada Declaration is designed to provide instructions only with regard to the withholding or withdrawal of life-sustaining treatment. If you want to make statements about your wishes regarding your medical care, you should do so in your Durable Power of Attorney for healthcare.

Any instructions you provide in your Declaration should be consistent with the instructions you provide in your Durable Power of Attorney for Healthcare. It also is a good idea to designate your agent as the person to make decisions regarding the withholding or withdrawal of life-sustaining treatment pursuant to your Declaration.

### **What if I change my mind?**

You may revoke your Declaration at any time and in any manner, regardless of your mental or physical condition.

Your revocation becomes effective once you or a witness to your revocation notify your doctor or other healthcare provider, who must then make your revocation a part of your medical record.

Due to restrictions in Nevada law, a pregnant patient's Nevada Declaration will not be honored if it is probable that the fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

Under Nevada law, you may either (1) direct your attending physician to withhold or withdraw life-sustaining treatment; *or* (2) designate another individual to make decisions governing the withholding or withdrawal of life-sustaining treatments. If you designate another individual to make these decisions, you should consider appointing the same person that you appointed to be your attorney-in-fact in your Durable Power of Attorney for Healthcare.

**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS  
– PAGE 1 OF 9**

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTHCARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE POWER TO MAKE HEALTHCARE DECISIONS FOR YOU. THIS POWER 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 TYPES OF TREATMENT OR PLACEMENTS 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 HEALTHCARE DECISIONS FOR YOURSELF.

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.

**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS  
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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.



**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE  
DECISIONS - PAGE 4 OF 9**

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ADD PROVISIONS  
AND LIMITATIONS  
TO YOUR AGENT'S  
POWER  
(IF ANY)

**4. SPECIAL PROVISION AND LIMITATIONS.**

(Your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for or other restrictions you wish to place on his or her authority, you should list them in the space below. If you do not write any limitations, your agent 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 agent is subject to the following special provisions and limitations:

PRINT THE  
EXPIRATION DATE  
(OPTIONAL)

YOU MAY WRITE  
YOUR OWN  
STATEMENT OF  
DESIRES  
(IF ANY) ON THE  
FOLLOWING PAGE

**5. DURATION.**

I understand that this power of attorney 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 power of attorney end on the following date:

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STATEMENT OF  
DESIRES  
(IF ANY)

INITIAL THE  
STATEMENTS THAT  
REFLECT  
YOUR WISHES  
(OPTIONAL)

ANY INSTRUCTIONS  
ON THE USE OF  
LIFE-SUSTAINING  
OR PROLONGING  
TREATMENTS  
SHOULD BE  
CONSISTENT WITH  
INSTRUCTIONS  
PROVIDED IN YOUR  
NEVADA  
DECLARATION, IF  
ANY

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### 6. STATEMENT OF DESIRES.

(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent 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 agent 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 below.)

*(If the statement reflects your desires, initial the line 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.

Initial \_\_\_\_\_

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.

Initial \_\_\_\_\_

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.

Initial \_\_\_\_\_

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.

Initial \_\_\_\_\_

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.

Initial \_\_\_\_\_

*(If you wish to change your answer, you may draw an "X" through the answer you do not want and circle the answer you prefer.)*

**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE  
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ADD FURTHER  
PERSONAL  
INSTRUCTIONS  
(IF ANY)

6. Other or Additional Statements of Desires:

DESIGNATION  
OF ALTERNATE  
ATTORNEY-IN-FACT  
(OPTIONAL)

7. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 3 in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1, is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

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

FIRST  
ALTERNATE

A. First Alternative Agent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

SECOND  
ALTERNATE

B. Second Alternative Agent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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SIGN AND DATE  
YOUR DOCUMENT  
AND PRINT YOUR  
CITY AND STATE

**8. PRIOR DESIGNATIONS REVOKED.**

I revoke any prior durable power of attorney for health care.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

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

\_\_\_\_\_ at  
(date)

\_\_\_\_\_, \_\_\_\_\_  
(city) (state)

\_\_\_\_\_  
(signature)

(THIS POWER OF ATTORNEY 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.)

**CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC**

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of Nevada )  
) ss.  
County of \_\_\_\_\_ )

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_,  
before

me, \_\_\_\_\_, personally appeared  
(name of notary public)

\_\_\_\_\_  
(name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. 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 SEAL**

\_\_\_\_\_  
(signature of notary public)

WITNESSING  
PROCEDURE

A NOTARY  
PUBLIC MUST  
COMPLETE THIS  
SECTION

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OR

**OR**

TWO WITNESSES  
MUST  
ACKNOWLEDGE  
YOUR SIGNATURE  
AND SIGN ON THE  
FOLLOWING  
PAGE

**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 agent, (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. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

WITNESSES  
MUST SIGN AND  
DATE YOUR  
DOCUMENT AND  
PRINT THEIR  
NAME AND  
ADDRESS

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 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 agent 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 care facility, nor an employee of an operator of a health care facility.

WITNESS # 1

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Residence Address: \_\_\_\_\_

WITNESS # 2

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ONE OF YOUR  
WITNESSES  
MUST ALSO  
AGREE WITH  
THIS STATEMENT  
AND SIGN  
BELOW

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION)

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: \_\_\_\_\_

Date: \_\_\_\_\_

Residence Address: \_\_\_\_\_

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

NEVADA DECLARATION – PAGE 1 OF 1

FILL IN MISSING INFORMATION IF IT REFLECTS YOUR WISHES

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 appoint or, if he or she is not reasonable available or is unwilling to serve, to make decisions on my behalf regarding direct my attending physician to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain. (If the person or persons I have so appointed are not reasonable available or are unwilling to serve, I direct my attending physician, pursuant to those sections, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.) Strike language in parentheses if you do not desire it.

INITIAL THIS STATEMENT IF IT REFLECTS YOUR WISHES. THIS SHOULD BE CONSISTENT WITH INSTRUCTIONS PROVIDED IN YOUR POWER OF ATTORNEY

If you wish to include this 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 gastrointestinal tract after all other treatments is withheld pursuant to this declaration.

Initial \_\_\_\_\_

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

The declarant voluntarily signed this writing in my presence.

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

Witness: \_\_\_\_\_

Address: \_\_\_\_\_

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ORGAN DONATION  
(OPTIONAL)

INITIAL THIS  
STATEMENT IF IT  
REFLECTS YOUR  
WISHES

ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

**ORGAN DONATION (OPTIONAL)**

In the hope that I may help others, I authorize my patient advocate to make this anatomical gift if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

Upon my death, I wish to donate:

- \_\_\_\_\_ My body for anatomical study if needed.
  - \_\_\_\_\_ Any needed organs, tissues, or eyes.
  - \_\_\_\_\_ Only the following organs, tissues, or eyes:
- 

I authorize the use of my organs, tissues, or eyes:

- \_\_\_\_\_ For transplantation
- \_\_\_\_\_ For therapy
- \_\_\_\_\_ For research
- \_\_\_\_\_ For medical education
- \_\_\_\_\_ For any purpose authorized by law

This authority granted to my patient advocate to make an anatomical gift is limited as follows (*here, list limitations or special wishes, if any*):

## **You Have Filled Out Your Advance Directive, Now What?**

1. Your Nevada Durable Power of Attorney for Healthcare Decisions and Nevada Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your attorney-in-fact and alternate attorney-in-fact, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your attorney-in-fact and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Nevada documents.
6. Be aware that your Nevada documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**