NEVADA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, 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.

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:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

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.
    - An *optional* advance directive form to use for adults with intellectual disabilities.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Only use the optional advance directive form for adults with intellectual disabilities for adults with significantly subaverage general intellectual functioning who have deficits in adaptive behavior.

4. 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.

5. 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, health care providers and/or faith leaders so that the form is available in the event of an emergency.

6. Nevada maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at www.livingwilllockbox.com.

7. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Nevada Advance Directive

This packet contains a legal document, a **Nevada Advance Directive**, that protects 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. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III. You must complete Part IV if you meet the prerequisites.

Part I is the **Nevada Durable Power of Attorney for Health Care Decisions,** which lets you name someone, called your agent, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. The power of attorney for health care decisions is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life. Part I also allows you to express your desires regarding your health care and other advance planning decisions, including your desires regarding life-sustaining treatments, in order to help guide your agent. Part I goes into effect when your doctor or advanced practice registered nurse determines in writing that you are no longer able to make or communicate your health care decisions.

Part II is a **Nevada Declaration**, which is your state's living will. Part II lets you state your wishes regarding the withholding and withdrawing of life-sustaining treatments, including the artificial administration of nutrition and hydration, in the event that you can no longer make your own health care decisions and you are terminally ill. The declaration in Part II becomes effective when—and is only effective when—your attending physician determines that (1) you are incapable of making decisions about the use of life-sustaining treatment and (2) you have a terminal condition. Because Part II is limited in this way and Part I allows you to express the same decisions, if you plan to complete Part I, you may wish to leave Part II blank and record your advance planning wishes in Part I only.

Part III contains the signature and witnessing provisions so that your document will be effective.

Part IV contains the certification of competency that must be filled out by an advanced practice registered nurse, physician, psychologist, or psychiatrist if you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care at the time of completing your advance directive.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Following the advance directive is an **Organ Donation Form**.

This packet also includes a legal document, a **Nevada Advance Directive for Adults with Intellectual Disabilities**, which may be used for adults with significantly subaverage general intellectual functioning and deficits in adaptive behavior.

Part I is the **Nevada Durable Power of Attorney for Health Care Decisions for Adults with Intellectual Disabilities,** which lets you name someone, called your agent, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. The power of attorney for health care decisions is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life.

Part II is an **End-of-Life Decisions Addendum Statement of Desires**, which is your state's living will for adults with intellectual disabilities. Part II lets you state your wishes regarding the withholding and withdrawing of life-sustaining treatments in the event that you can no longer make your own health care decisions and you are terminally ill.

This packet also includes a legal document, a **Nevada Advance Directive for Adults with Dementia**.

Part I is the **Nevada Durable Power of Attorney for Health Care Decisions for Adults with Dementia**, which lets you name someone, called your agent, to make decisions about your health care if you can no longer speak for yourself.

Part II is an **End-of-Life Decisions Addendum Statement of Desires**, which is your state's living will for adults with any form of dementia. Part II lets you state your wishes regarding the withholding and withdrawing of life-sustaining treatments in event that you can no longer make your own health care decisions and you are termination ill.

Note: These documents will be legally binding only if the person completing them is a competent adult who is at least 18 years of age.

Instructions for Completing Your Nevada Advance Directive

How do I make my Nevada Advance Directive legal?

Nevada requires that you execute your form using the Nevada statutory language, which is reflected in the forms below.

If you fill out Part I, you can make your advance directive legal in one of two ways.

1. Sign your document in the presence of two witnesses and use the Nevada statutory language. These witnesses cannot be:
    - the person you name as your agent,
    - a health care provider,
    - an employee of a health care provider,
    - an operator of a health care facility, or
    - an employee or an operator of a health care facility.

    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.

    Signing your document in this way will also make Part II legal.

    OR

2. Have your signature witnessed by a notary public and use the Nevada statutory language. Having your signature notarized will only make Part I legal (*i.e.*, Part II needs an additional witness besides the notary).

If you fill out Part II, you must sign your form in front of two witnesses and use the Nevada statutory language.

Regardless of whether you fill out Part I or Part II, if you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care, you must obtain a certification of competency filled out by an advanced practice registered nurse, physician, psychologist, or psychiatrist at the time you complete these documents.

Whom should I appoint as my agent?
Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care 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 health care provider,
- an employee of your health care provider,
- an operator of a health care facility, or
- an employee of a health care 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.

Should I add personal instructions to my Nevada Advance Directive?
One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?
You may revoke your advance directive at any time in any manner that expresses your intent.

You may revoke the appointment of your agent (Part I) at any time by notifying your agent or your treating physician, hospitals, or other health care provider orally or in writing.

Your durable power of attorney (Part I) is automatically revoked if:

- you execute a new durable power of attorney, or
- you appoint your spouse as your agent and your marriage ends (unless you state otherwise under Part I).

If you wish to set an expiration date for your durable power of attorney (Part I), you may do so on page 4, section 5. If you do not set an expiration date, your durable power of attorney remains valid until it is revoked.

Revocation of your declaration (Part II) is effective when you notify your attending physician.

What other important facts should I know?
A direction to withhold or withdraw life-sustaining treatment from a pregnant patient is not effective if it is probable that the fetus would survive to the point of live birth with continued life-sustaining treatment.

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 (punishment meant to encourage or discourage behavior)
- Experimental, biomedical, or behavioral treatment, or participation in any medical, biomedical, or behavioral research program
- Any other treatment for which you, in your Durable Power of Attorney for Health Care (Part I), state that your agent may not consent.

The **Nevada Advance Directive for Adults with Intellectual Disabilities** follows the rules described above. The **Nevada Advance Directive for Adults with Intellectual Disabilities** is printed in a different font for ease of reference.

Part I. Nevada Durable Power of Attorney For Health Care Decisions

WARNING TO PERSON 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:

STATUTORY WARNING

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE POWER TO MAKE HEALTH CARE 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 OR ADVANCED PRACTICE REGISTERED NURSE 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.

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

STATUTORY WARNING (CONTINUED)

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 DECIDE WHERE YOU LIVE, EVEN AS YOU AGE. DECISIONS ABOUT WHERE YOU LIVE ARE PERSONAL, SOME PEOPLE LIVE AT HOME WITH SUPPORT, WHILE OTHERS MOVE TO ASSISTED LIVING FACILITIES OR FACILITIES FOR SKILLED NURSING. IN SOME CASES, PEOPLE ARE MOVED TO FACILITIES WITH LOCKED DOORS TO PREVENT PEOPLE WITH COGNITIVIE DISORDERS FROM LEAVING OR GETTING LOST OR TO PROVIDE ASSISTANCE TO PEOPLE WHO REQUIRE A HIGHER LEVEL OF CARE. YOU SHOULD DISCUSS WITH THE PERSON DESIGNATED IN THIS DOCUMENT YOUR DESIRES ABOUT WHERE YOU LIVE AS YOU AGE OR IF YOUR HEALTH DECLINES. YOU HAVE THE RIGHT TO DETERMINE WHETHER TO AUTHORIZE THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE DECISIONS FOR YOU ABOUT WHERE YOU LIVE WHEN YOU ARE NO LONGER CAPABLE OF MAKING THAT DECISION. IF YOU DO NOT PROVIDE SUCH AUTHORIZATION TO THE PERSON DESIGNATED IN THIS DOCUMENT, THAT PERSON MAY NOT BE ABLE TO ASSIST YOU TO MOVE TO A MORE SUPPORTIVE LIVING ARRANGEMENT WITHOUT OBTAINING APPROVAL THORUGH A JUDICIAL PROCESS.

7. 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.

8. 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, ADVANCED PRACTICE REGISTERED NURSE, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

9. 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.

10. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

11. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

STATUTORY WARNING (CONTINUED)

12. YOU MAY REQUEST THAT THE NEVADA SECRETARY OF STATE ELECTRONICALLY STORE WITH THE NEVADA LOCKBOX A COPY OF THIS DOCUMENT TO ALLOW ACCESS BY AN AUTHORIZED PROVIDER OF HEALTH CARE AS DEFINED IN NRS 629.031.

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR AGENT

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____, do hereby designate and appoint:
(name)

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

as my Agent 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 agent to make health care decisions for you. Unless the person you designate is your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your agent: (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 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 by appointing the person designated above to make health care decisions for me. This power of attorney 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 agent 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; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required to obtain medical care and/or medical and hospital records, EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility, and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

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:

ADD ADDITIONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE SCOPE OF YOUR AGENT'S AUTHORITY

_____

_____

_____

_____

_____

_____

_____

_____

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.

PRINT THE EXPIRATION DATE (OPTIONAL)

I wish to have this power of attorney end on the following date:

_____

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.)

INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES (OPTIONAL)

A. 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 _____

B. If I am in a coma which my doctors or advanced practice registered nurses have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments **not** be used.

Initial _____

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

C. 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 _____

D. 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 _____

E. 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, circle the answer you prefer, and initial the changes)*

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

Other or Additional Statements of Desires:

(Attach additional pages if needed)

7. STATEMENT OF DESIRES CONCERNING LIVING ARRANGEMENTS.

INITIAL THE RESPONSES THAT REFLECT YOUR WISHES (OPTIONAL)

A. I desire to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my activities of daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me.

Initial _____

B. I desire to live in my home for as long as possible without regard for my medical needs, personal safety or ability to engage in activities of daily living. My agent may arrange for a natural person, an employee of an agency or a provider of community-based services to come into my home and provide care for me. I understand that, before I may be placed in a facility or home other than the home in which I currently reside, a guardian must be appointed for me.

Initial _____

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR LIVING ARRANGEMENTS.

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

Other or Additional Statements of Desires:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternate agent but you may do so. Any alternate 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:

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR FIRST ALTERNATE AGENT

A. First Alternate Agent

Name: _____

Address: _____

Telephone Number: _____

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR SECOND ALTERNATE AGENT

B. Second Alternate Agent

Name: _____

Address: _____

Telephone Number: _____

9. PRIOR DESIGNATIONS REVOKED.
I revoke any prior durable power of attorney for health care.

10. WAIVER OF CONFLICT OF INTEREST.

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

11. CHALLENGES.

If the legality of any provision of this durable power of attorney for health care is questioned by my physician, my advanced practice registered nurse, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. The durable power of attorney for health care must be construed and interpreted in accordance with the laws of the State of Nevada.

This section is not required, and you may cross it out if you desire.

12. NOMINATION OF GUARDIAN.

If, after execution of this durable power of attorney for health care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

12. RELEASE OF INFORMATION.

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

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

PART II ONLY APPLIES TO WITHHOLDING OR WITHDRAWING OF LIFE-SUSTAINING TREATMENTS IF YOU ARE TERMINALLY ILL

BECAUSE PART II IS LIMITED IN THIS WAY, IF YOU PLAN TO COMPLETE PART I, YOU MAY WISH TO LEAVE PART II BLANK AND RECORD YOUR ADVANCE PLANNING WISHES IN PART I.

INITIAL ONLY ONE

ADD ADDITIONAL INSTRUCTIONS, IF ANY, IN THE EVENT YOU HAVE A TERMINAL CONDITION

ATTACH ADDITIONAL PAGES IF NEEDED

If I should lapse into 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 (a terminal condition) and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Nevada Uniform Act on the Rights of the Terminally Ill, to:

_____ 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 agent appointed under a durable power of attorney for health care (Part I), if I have appointed one.

I further direct that:

_____

_____

_____

_____

(Attach additional pages if needed)

PART III: EXECUTION

Nevada requires that you execute your form using the Nevada statutory language, which is reflected in the forms below.

If you fill out Part II, you must sign your form in front of two witnesses and use the Nevada statutory language.

If you fill out Part I, you can make your advance directive legal in one of two ways.

1. Sign your document in the presence of two witnesses and use the Nevada statutory language. These witnesses cannot be:
   - the person you name as your agent,
   - a health care provider,
   - an employee of a health care provider,
   - an operator of a health care facility, or
   - an employee or an operator of a health care facility.

   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.

   Signing your document in this way will also make Part II legal.

   OR

2. Have your signature witnessed by a notary public and use the Nevada statutory language. Having your signature notarized will only make Part I legal (i.e., Part II needs an additional witness besides the notary).

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.

IF YOU FILLED OUT PART II, YOU MUST HAVE YOUR DOCUMENT WITNESSED

Alternative No. 1: Sign before witnesses.

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

_____ at _____,_____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____
(signature)

_____
(print name)

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, and 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 or an employee of an operator of a health care facility.

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

REQUIRED STATEMENT BY ONE OF THE ABOVE WITNESSES IF YOU FILLED OUT PART I

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that 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: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY AN OPTION IF YOU DID NOT FILL OUT PART II

Alternative No. 2: Sign before a notary public.

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

_____ at _____,_____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____
(signature)

_____
(print name)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

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.

NOTARY SEAL

_____
(signature of notary public)

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

ASK YOUR TREATING ADVANCED PRACTICE REGISTERED NURSE, PHYSICIAN, PSYCHOLOGIST, OR PSYCHIATRIST TO FILL THIS OUT

PART IV: CERTIFICATION OF COMPETANCY

If you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care, Nevada requires that you include a certification of competency from an advanced practice registered nurse, physician, psychologist, or psychiatrist along with your power of attorney:

The undersigned treating (advanced practice registered nurse/physician/psychologist/psychiatrist) of _____ states as follows:

PRINT YOUR NAME HERE

1. That I am a licensed (advanced practice registered nurse/physician/psychologist/psychiatrist) practicing in the State of _____, and I have been a licensed (advanced practice registered nurse/physician/psychologist/psychiatrist) for ____ years. My present address is _____.

PRINT YOUR NAME HERE

2. That I have examined _____ and have concluded as a result of that examination that the he/she is mentally competent to understand the nature of the Durable Power of Attorney for Health Care proceedings and the delegation of authority to an agent.

_____

(Signature of certifying advanced practice registered nurse/physician/psychologist/psychiatrist) (Date)

_____

(Name of certifying advanced practice registered nurse/physician/psychologist/psychiatrist)

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

NEVADA ORGAN DONATION FORM – PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Nevada law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Nevada law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____
_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____
_____

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

INSERT YOUR NAME

INSERT YOUR ADDRESS

PRINT THE NAME OF YOUR AGENT

THIS FORM SHOULD ONLY BE USED FOR ADULTS WITH INTELLECTUAL DISABILITIES[1]

PART 1. DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

My name is: _____
(insert your name)

and my address is: _____
(insert your address).

I would like to designate _____
(insert the name of the person you wish to designate as your agent for health care decisions for you) as my agent for health care decisions for me if I am sick or hurt and need to see a doctor or an advanced practice registered nurse or go to the hospital. I understand what this means.

If I am sick or hurt, my agent should take me to the doctor or an advanced practice registered nurse. If my agent is not with me when I become sick or hurt, please contact my agent and ask him or her to come to the doctor's or advanced practice registered nurse's office. I would like the doctor or advanced practice registered nurse to speak with my agent and me about my sickness or injury and whether I need any medicine or other treatment. After we speak with the doctor or advanced practice registered nurse, I would like my agent to speak with me about the care or treatment. When we have made decisions about the care or treatment, my agent will tell the doctor or advanced practice registered nurse about our decisions and sign any necessary papers.

If I am very sick or hurt, I may need to go to the hospital. I would like my agent to help me decide if I need to go to the hospital. If I go to the hospital, I would like the people who work at the hospital to try very hard to care for me. If I am able to communicate, I would like the doctor or advanced practice registered nurse at the hospital to speak with me and my agent about what care or treatment I should receive, even if I am unable to understand what is being said about me. After we speak with the doctor or advanced practice registered nurse, I would like my agent to help me decide what care or treatment I should receive. Once we decide, my agent will sign any necessary paperwork. If I am unable to communicate because of my illness or injury, I would like my agent to make decisions about my care or treatment based on what he or she thinks I would do and what is best for me.

[1] "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

I would like my agent to help me decide if I need to see a dentist and help me make decisions about what care or treatment I should receive from the dentist. Once we decide, my agent will sign any necessary paperwork.

I would also like my agent to be able to see and have copies of all my medical records. If my agent requests to see or have copies of my medical records, please allow him or her to see or have copies of the records.

I understand that my agent cannot make me receive any care or treatment that I do not want. I also understand that I can take away this power from my agent at any time, either by telling him or her that they are no longer my agent or by putting it in writing.

If my agent is unable to make health care decisions for me, then I designate_____ (insert the name of another person you wish to designate as your alternative agent to make health care decisions for you) as my agent to make health care decisions for me as authorized in this document.

INSERT THE NAME OF ANOTHER PERSON YOU WISH TO DESIGNATE AS YOUR ALTERNATIVE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.

(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)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE.

Signature: _____

THE HEALTH CARE AGENT MUST COMPLETE THIS PORTION.

2. AGENT SIGNATURE.

THE AGENT MUST WRITE IN THE NAME OF THE PRINCIPAL (THE PERSON WHO IS CREATING THIS ADVANCE DIRECTIVE).

As agent for_____(insert name of principal), I agree that a physician, advanced practice registered nurse, health care facility or other provider of health care, acting in good faith, may rely on this power of attorney for health care and the signatures herein, and I understand that pursuant to NRS 162A.815, a physician, advanced practice registered nurse, health care facility or other provider of health care that in good faith accepts an acknowledged power of attorney for health care is not subject to civil or criminal liability or discipline for unprofessional conduct for giving effect to a declaration Contained within the power of attorney for health care or for following the direction of an agent named in the power of attorney for health care.

THE AGENT MUST COMPLETE THIS PORTION.

I also agree that:

1. I have a duty to act in a manner consistent with the desires of_____(insert name of principal) as stated in this document or otherwise made known by _____ (insert name of principal), or if his or her desires are unknown, to act in his or her best interest.

2. If _____ (insert name of principal) revokes this power of attorney at any time, either verbally or in writing, I have a duty to inform any persons who may rely on this document, including, without limitation, treating physicians, advanced practice registered nurses, hospital staff or other providers of health care, that I no longer have the authorities described in this document.

3. The provisions of NRS 162A.840 prohibit me from being named as an agent to make health care decisions in this document if I am a provider of health care, an employee of the principal's provider of health care or an operator or employee of a health care facility caring for the principal, unless I am the spouse, legal guardian or next of kin of the principal.

4. The provisions of NRS 162A.850 prohibit me from consenting to the following types of care or treatments on behalf of the principal, including, without limitation:

(a) Commitment or placement of the principal in a facility for treatment of mental illness;

(b) Convulsive treatment;

(c) Psychosurgery;

(d) Sterilization;

(e) Abortion;

(f) Aversive intervention, as it is defined in NRS 449.766;

(g) Experimental medical, biomedical or behavioral treatment, or participation in any medical, biomedical or behavioral research program; or

(h) Any other care or treatment to which the principal prohibits the agent from consenting in this document.

THE AGENT MUST COMPLETE THIS PORTION.

5. End-of-life decisions must be made according to the wishes of _____ (insert name of principal), as designated in the attached addendum. If his or her wishes are not known, such decisions must be made in consultation with the principal's treating physicians or advanced practice registered nurses.

(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 YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

Alternative No. 1: Agent signs before witnesses.

THE AGENT MUST SIGN AND PRINT HERE

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

STATEMENT OF WITNESSES

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) THE PRINCIPAL'S HEALTH CARE PROVIDER;
(4) THE OPERATOR OF A HEATLH 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 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 health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

(At least one witness must sign the attestation on the following page)

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

(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 that 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: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 2: Agent Signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

On this _____ day of _____, in the year _____,
before me, _____, personally appeared
(name of notary public)

_____
(name of principal)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

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.

NOTARY SEAL

_____
(signature of notary public)

PART II. END–OF–LIFE DECISIONS ADDENDUM STATEMENT OF DESIRES

You can, but are not required to, state what you want to happen if you get very sick and are not likely to get well. You do not have to complete this form, but if you do, your agent must do as you ask if you cannot speak for yourself.

_____(insert name of agent) might have to decide, if you get very sick, whether to continue with your medicine or to stop your medicine, even if it means you might not live_____(insert name of agent) will talk to you to find out what you want to do, and will follow your wishes.

If you are not able to talk to_____(insert name of agent), you can help him or her make these decisions for you by letting your agent know what you want.

Here are your choices. Please circle yes or no to each of the following statements and sign your name below:

FOR EACH QUESTION CIRCLE YES OR NO (CIRCLE ONLY ONE CHOICE)

1. I want to take all the medicine and receive any treatment I can to keep me alive regardless of how the medicine or treatment makes me feel. YES NO

2. I do not want to take medicine or receive treatment if my doctors or advanced practice registered nurses think that the medicine or treatment will not help me. YES NO

3. I do not want to take medicine or receive treatment if I am very sick and suffering and the medicine or treatment will not help me get better. YES NO

4. I want to get food and water even if I do not want to take medicine or receive treatment. YES NO

YOU MUST SIGN AND DATE THIS END-OF-LIFE DECISIONS ADDENDUM

I sign my name to this End-of-Life Decisions Addendum on

_____ at _____,_____.
(date) (city) (state)

Signature: _____

THE AGENT MUST SIGN AND PRINT HERE

(THIS END-OF-LIFE DECISIONS ADDENDUM WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

Alternative No. 1: Agent signs before witnesses.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) THE PRINCIPAL'S HEALTH CARE PROVIDER;
(4) THE OPERATOR OF A HEATLH CARE FACILITY; OR
(5) AN EMPLOYEE OF AN OPERATOR OF A HEALTH CARE FACILITY

STATEMENT OF WITNESSES

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 health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

(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 that 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: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

Alternative No. 2: Agent Signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

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.

NOTARY SEAL

_____

(signature of notary public)

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

PART 1. DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

INSERT YOUR NAME

My name is:

_____
(insert your name)

INSERT YOUR ADDRESS

and my address is:

_____
(insert your address).

PRINT THE NAME OF YOUR AGENT

I would like to designate

_____
(insert the name of the person you wish to designate as your agent for health care decisions for you) as my agent for health care decisions for me if I am sick or hurt and need to see a doctor or go to the hospital. I understand what this means.

If I am sick or hurt, my agent should take me to the doctor. If my agent is not with me when I become sick or hurt, please contact my agent and ask him or her to come to the doctor's office. I would like the doctor to speak with my agent and, if I have the capacity to understand, me about my sickness or injury and whether I need any medicine or other treatment. After we speak with the doctor, if I have the capacity to understand, I would like my agent to speak with me about the care or treatment. When we have made decisions about the care or treatment, my agent will tell the doctor about our decisions and sign any necessary papers.

If I am very sick or hurt, I may need to go to the hospital. I would like my agent to help me decide if I need to go to the hospital. If I go to the hospital, I would like the people who work at the hospital to try very hard to care for me. If I am able to communicate, I would like the doctor at the hospital to speak with me and my agent about what care or treatment I should receive, even if I am unable to understand what is being said about me. After we speak with the doctor, I would like my agent to help me decide what care or treatment I should receive. Once we decide, my agent will sign any necessary paperwork. If I am unable to communicate because of my illness or injury, I would like my agent to make decisions about my care or treatment based on what he or she thinks I would do and what is best for me.

I would like my agent to help me decide if I need to see a dentist and help me make decisions about what care or treatment I should receive from the dentist. Once we decide, my agent will sign any necessary paperwork.

I would also like my agent to be able to see and have copies of all my medical records. If my agent requests to see or have copies of my medical records, please allow him or her to see or have copies of the records.

I understand that my agent cannot make me receive any care or treatment that I do not want. I also understand that I can take away this power from my agent at any time, either by telling by telling my agent that he or she is no longer my agent or by putting it in writing.

INSERT THE NAME OF ANOTHER PERSON YOU WISH TO DESIGNATE AS YOUR ALTERNATIVE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.

If my agent is unable to make health care decisions for me, then I designate _____ (insert the name of another person you wish to designate as your alternative agent to make health care decisions for your) as my agent to make health care decisions for me as authorized in this document.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE.

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

_____ at _____,_____.
(date) (city) (state)

Signature: _____

AGENT SIGNATURE:

THE HEALTH CARE AGENT MUST COMPLETE THIS PORTION.

THE AGENT MUST WRITE IN THE NAME OF THE PRINCIPAL (THE PERSON WHO IS CREATING THIS ADVANCE DIRECTIVE).

As agent for _____ (insert name of principal), I agree that a physician, health care facility or other provider of health care, acting in good faith, may rely on this power of attorney for health care and the signatures herein, and I understand that pursuant to NRS 162A.815, a physician, health care facility or other provider of health care that in good faith accepts an acknowledge power of attorney for health care is not subject to civil or criminal liability or discipline for unprofessional conduct for giving effect to a declaration contained within the power of attorney for health care or for following the direction of an agent named in the power of attorney for health care.

I also agree that:

1. I have a duty to act in a manner consistent with the desires of _____ (insert name of principal) as stated in this document or otherwise made known by _____ (insert name of principal), or if his or her desires are unknown, to act in his or her best interest.

2. If _____ (insert name of principal) revokes this power of attorney at any time, either verbally or in writing, I have a duty to inform any persons who may rely on this document, including, without limitation, treating physicians, hospital staff or other providers or health care, that I no longer have the authorities described in this document.

3. The provisions of NRS 162A.840 prohibit me from being named as an agent to make health care decisions in this document if I am a provider of health care, an employee of the principal's provider of health care or an operator or employee of a health care facility caring for the principal, unless I am the spouse, legal guardian or next of kin of the principal.

4.The provisions of NRS 162A.850 prohibit me from consenting to the following types of care or treatments on behalf of the principal, including, without limitation:

(a) Commitment or placement of the principal in a facility for treatment of mental illness;

(b) Convulsive treatment;

(c) Psychosurgery;

(d) Sterilization;

(e) Abortion;

(f) Aversive intervention, as it is defined in NRS 449.766;

(g) Experimental medical, biomedical or behavioral treatment, or participation in any medical, biomedical or behavioral research program; or

(h) Any other care or treatment to which the principal prohibits the agent from consenting in this document.

5. End-of-life decisions must be mde according to the wishes of _____ (insert name of principal), as designated in the attached addendum. If his or her wishes are not known, such decisions must be made in consultation with the principal's treating physicians.

THE AGENT MUST SIGN AND PRINT HERE

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) A HEALTH CARE PROVIDER
(4) THE OPERATOR OF A HEATLH CARE FACILITY; OR
(5) AN EMPLOYEE OF AN OPERATOR OF A HEALTH CARE FACILITY

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 YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

Alternative No. 1: Agent signs before witnesses.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

STATEMENT OF WITNESSES

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 health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

(At least one witness must sign the attestation on the following page)

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

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 that 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: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 2: Agent Signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

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.

NOTARY SEAL

_____
(signature of notary public)

Note: 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.

PART 2. END-OF-LIFE DECISIONS ADDENDUM STATEMENT OF DESIRES.

You can, but are not required to, state what you want to happen if you get very sick and are not likely to get well. You do not have to complete this form, but if you do, your agent must do as you ask if you cannot speak for yourself.

_____(insert name of agent) might have to decide, if you get very sick, whether to continue with your medicine or to stop your medicine, even if it means you might not live_____(insert name of agent) will talk to you to find out what you want to do, and will follow your wishes.

If you are not able to talk to_____(insert name of agent), you can help him or her make these decisions for you by letting your agent know what you want.

Here are your choices. Please circle yes or no to each of the following statements and sign your name below:

FOR EACH QUESTION CIRCLE YES OR NO (CIRCLE ONLY ONE CHOICE)

1. I want to take all the medicine and receive any treatment I can to keep me alive regardless of how the medicine or treatment makes me feel. YES NO

2. I do not want to take medicine or receive treatment if my doctors or advanced practice registered nurses think that the medicine or treatment will not help me. YES NO

3. I do not want to take medicine or receive treatment if I am very sick and suffering and the medicine or treatment will not help me get better. YES NO

4. I want to get food and water even if I do not want to take medicine or receive treatment. YES NO

YOU MUST SIGN AND DATE THIS END-OF-LIFE DECISIONS ADDENDUM.

I sign my name to this End-of-Life Decisions Addendum on

_____ at _____,_____.
(date) (city) (state)

Signature: _____

THIS END-OF-LIFE DECISIONS ADDENDUM WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE; OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

Alternative No. 1: Agent signs before witnesses.

THE AGENT MUST SIGN AND PRINT HERE

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

STATEMENT OF WITNESSES

THE FOLLOWING INDIVIDUALS CANNOT SERVE AS WITNESSES:
(1) A MINOR;
(2) THE AGENT;
(3) A HEALTH CARE PROVIDER
(4) THE OPERATOR OF A HEATLH 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 End-of-Life Decisions Addendum 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 health care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

(At least one witness must sign the attestation on the following page)

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

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 that 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: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

SIGNING BEFORE A NOTARY PUBLIC IS ONLY NECESSARY IF YOU DID NOT SIGN BEFORE TWO WITNESSES

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Alternative No. 2: Agent signs before a notary public.

Signature: _____ Relationship to principal:

Print Name: _____ _____

Date: _____ Length of relationship to principal: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

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.

NOTARY SEAL

_____
(signature of notary public)

Note: You should retain an executed copy of this document and give one to your agent. The End-of-Life Decisions Addendum should be available so a copy may be given to your providers of health care.

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

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Nevada Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. Nevada maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at www.livingwilllockbox.com.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your Nevada document.

8. Be aware that your Nevada document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Nevada law authorizes the use of a Physician Order for Life–Sustaining Treatment (POLST) form, which is designed to help health care providers honor your wishes regarding CPR and other health care decisions. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

2020AD

OR donate online today: www.NationalHospiceFoundation.org/donate