NEVADA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

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. 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.

4. Once the form is completed and signed, photocopy, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or 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. 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 *https://www.nvsos.gov/sos/online-services/nevada-lockbox*.

INTRODUCTION TO YOUR NEVADA ADVANCE HEALTH CARE 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.

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 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.

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.**

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

How do I make my Nevada Advance Health Care 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.

Option 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

Option 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 that is included in the form.

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?

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 advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Part I, **Nevada Durable Power of Attorney for Health Care Decisions**, 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, the **Declaration**, 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.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

A directive 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.

Your agent will be bound by the current laws of Nevada as they regard pregnancy and termination of pregnancies.

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.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

The state of Nevada also has 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 and a **Nevada Advance Directive for Adults with Dementia**. You should see you healthcare provider or attorney if you believe you need these forms.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

STATUTORY WARNING

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:

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)

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

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 _____

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)

INITIAL THE RESPONSES THAT REFLECT YOUR WISHES (OPTIONAL)

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR LIVING ARRANGEMENTS.

7. STATEMENT OF DESIRES CONCERNING LIVING ARRANGEMENTS.

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 _____

(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 IN ADDITION TO BEING NOTARIZED

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

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

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

Alternative No. 1: Sign before witnesses.

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

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

_____
(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.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

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: _____ _____

IF YOU FILLED OUT PART 2, YOU MUST SIGN BEFORE A NOTARY

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

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

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)

_____
(signature)

_____
(print name)

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)

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

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

www.caringinfo.org