Nebraska Power of Attorney for Health Care

I appoint –_____, whose address is
_____
_____,
And whose telephone number is (_____)_____ - _____, as my attorney-in-fact for health care. I appoint –
_____, whose address is _____
_____
_____,
And whose telephone number is (_____)_____ - _____, as my successor attorney-in-fact for health care. I authorize my attorney-in-fact appointed by this document to make healthcare decisions. I have read the warnings stated in this document and understand the consequences of executing a power of attorney for health care.

I direct that my attorney-in-fact comply with the following instructions or limitations:
I direct my attorney-in-fact to authorize the withholding or withdrawal of any medical procedure, treatment, or intervention that uses mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function which would, when applied to me, serve only to prolong my dying process or persistent vegetative state.

I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment:
If I should pass into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment which could include but is not limited to artificially administered nutrition and hydration, will, in the opinion of my attending physician, serve only to prolong my dying process or persistent vegetative state, I direct my attorney-in-fact to authorize with withholding or withdrawal of life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

I direct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:
I direct my attorney-in-fact to authorize the withholding or withdrawal of artificially administered nutrition and hydration which would, when given to me, serve only to prolong my dying process or my persistent vegetative state.
I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY-IN-FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

DECLARANT SIGNATURE

Signed this_____day of_____, 20____

_____ _____
Signature Printed Name

_____ _____
Social Security Number Printed Address

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged this or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind that not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney-in-fact by this document.

Witnessed By:

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

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

-OR-
NOTARY

(You may sign this document before a notary public instead of having it witnessed above.) State of Nebraska)
) SS.
County of _____)

_____
Notary Public
My commission expires _____

RIGHTS OF THE TERMINALLY ILL DECLARATION

(NEBRASKA LIVING WILL DECLARATION)

If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

DECLARANT SIGNATURE

Signed this_____day of_____, 20____

_____ Signature

_____ Printed Name

_____ Social Security Number

_____ Printed Address

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged this or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind that not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney-in-fact by this document.

Witnessed By:

_____ (Signature of Witness/Date)

_____ (Printed Name of Witness)

_____ (Signature of Witness/Date)

_____ (Printed Name of Witness)

-OR-
NOTARY

(You may sign this document before a notary public instead of having it witnessed above.) State of Nebraska)
) SS.
County of _____)

_____
Notary Public
My commission expires _____