

# Handout 6: Completed Sample Forms

## NEBRASKA POWER OF ATTORNEY FOR HEALTH CARE

### Instructions

Print the name, address, and telephone number of your power of attorney

I appoint Mary Jones,

Whose address is 48880 Sugarplum, Omaha, NE 68100,

And whose telephone number is 402-XXX-XXXX,

as my power of attorney for health care.

Print the name, address, and telephone number of your alternate power of attorney

I appoint Susan Doe,

Whose address is 15793 Ocean Avenue, Bangkor, MA,

And whose telephone number is 1-508-XXX-XXXX,

as my successor power of attorney for health care.

I authorize my power of attorney appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

Add General Instructions (if any)

I direct that my power of attorney comply with the following instructions or limitations: (optional)

*I have lived a good life and am ready, when the Lord calls, to die.*

*As my health care power of attorney, please provide support for my remaining family and keep them informed of my status (if able to contact them in a reasonable manner).*

*Qualities of life, being useful and contributing to society are of*

*concern to me. I do not desire to be a burden to my children or grandchildren and you need not exhaust my finances, my insurance benefits or pursue heroic measures to extend my life. I am content to accept that life has a beginning and an end.*

*Please contact the clergy at my church to visit me, if available.*

*Please play hymns while I am unconscious or terminal. Periodically read favorite scriptures such as: Hebrews 11:1-3, 2 Corinthians 5:1-10, Psalm 23, Psalm 91, Deuteronomy 6:4-9, 2 Samuel 6:13-15 and others.*

*Above all, I want my family to know I love God, love them and want them to celebrate the life we led. If there are any areas of offense to you personally that I am guilty of, I ask your forgiveness. My family needs to move forward after my death as a means of honoring the efforts I have made to provide for them and their future. Love God, love each other and pursue a life that praises the Savior. Take time to enjoy life.*

*Contact Hospice*

# NEBRASKA POWER OF ATTORNEY FOR HEALTH CARE

PAGE 2 OF 4

State your directions for the use of life-sustaining treatment (if any)

I direct that my power of attorney comply with the following instructions on life-sustaining treatment: (optional)

*If terminally ill, or it is determined I have a condition that will shortly cause my death, or if unconscious with no hope of being cognizant of my environment (e.g. irreversible coma or brain dead), or in an accident where I would need to be kept alive using machines or drugs. I do not authorize CPR/AED, mechanical breathing or other equally life-sustaining treatments. I request being kept hygienically clean and free of pain.*

State your directions for the use of artificial nutrition and hydration (if any)

I direct that my power of attorney comply with the following instructions on artificially administered nutrition and hydration: (optional)

*If terminally ill, or it is determined I have a condition that will shortly cause my death, or if unconscious with no hope of being cognizant of my environment (e.g. irreversible coma or brain dead), or in an accident where I would need to be kept alive using machines or drugs. Do not authorize nutritional support or hydration.*

*In the event I have an illness from which I could recover, utilize hydration and nutrition interventions for a reasonable period of time, however, if no clear indication of improvement, discontinue the nutritional/hydration measures.*

Cross out this statement if you do not authorize your power of attorney to make an anatomical gift of your organs or physical parts

I authorize my power of attorney to make the following anatomical gift if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give:

- (a) X any needed organs or tissues.
- (b) \_\_\_ only the following organs or tissues (*specify below the organ(s) or tissues, if any, that you wish to donate*):
- (c) \_\_\_ my body for anatomical study, if needed.

I donate these organs/tissues for:

\_\_\_ purposes of transplantation, therapy, medical research or education;

X any legal purpose

The authority granted to my power of attorney to make an anatomical gift is limited as follows (*here list any limitations or special wishes*):

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 POWER OF ATTORNEY, 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 INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Bob Smith

(signature of person making designation)

11/5/2008

(date)

NEBRASKA POWER OF ATTORNEY FOR HEALTH CARE

PAGE 3 OF 4

Witnessing  
Procedure

Your witness must  
print their names  
and sign and date  
your document

**DECLARATION OF WITNESSES**

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

**Witnessed by:**

Witness #1

Jeremiah Reed  
(signature of witness)

11/5/2008  
(date)

Jeremiah Reed  
(printed name of witness)

Witness #2

Jennifer Barry  
(signature of witness)

11/5/2008  
(date)

Jennifer Barry  
(printed name of witness)

NEBRASKA POWER OF ATTORNEY FOR HEALTH CARE

PAGE 4 OF 4

OR

Or a notary public should complete this section of your document.

State of Nebraska, )  
 ) ss.  
County of \_\_\_\_\_ )

On this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_, before me,  
\_\_\_\_\_, a notary public in and  
for \_\_\_\_\_ County, personally  
came \_\_\_\_\_, personally

Known to be the identical person whose name is affixed to the above power of attorney for health care as principal, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney-in-fact or successor attorney-in-fact designated by this power of attorney for health care.

Witness my hand and notarial seal at

\_\_\_\_\_ in such county the day and year last above written.

SEAL

\_\_\_\_\_  
*signature of notary public*