

NEBRASKA POWER OF ATTORNEY FOR HEALTHCARE

Instructions

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

I appoint _____,

Whose address is _____,

And whose telephone number is _____,

as my power of attorney for health care.

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

I appoint _____,

Whose address is _____,

And whose telephone number is _____,

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.

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

Add General
Instructions
(if any)

(continued)

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)

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)

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) ___ 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;
- ___ 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.

(signature of person making designation)

(date)

NEBRASKA POWER OF ATTORNEY FOR HEALTH CARE

PAGE 3 OF 4

Witnessing
Procedure

DECLARATION OF WITNESSES

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

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

(signature of witness)

(date)

(printed name of witness)

Witness #2

(signature of witness)

(date)

(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

NEBRASKA DECLARATION - LIVING WILL

PAGE 1 OF 2

Instructions

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.

Add personal instructions (if any)

Other directions:

Sign and date your document
Print your address
Move to the next page to have your document witnessed

Signed this _____ day of _____

Signature _____

Address _____

NEBRASKA DECLARATION - LIVING WILL

PAGE 2 OF 2

Witnessing Procedure

Your two witnesses
must sign your
document and print
their addresses

The declarant voluntarily signed this writing in my presence.

Witness _____

Address _____

Witness _____

Address _____

Or

OR

A Notary Public
must sign your
document here

The declarant voluntarily signed this writing in my presence.

Notary Public