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:

A. ***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.***

B. ***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.***

C. ***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 not giving treatment or stopping treatment which would keep you alive.***

D. ***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.***

E. ***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 given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.***

F. ***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.***

G. ***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, hospital, or other provider of health care orally or in writing.***

H. ***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.***

I. ***This document revokes any prior Durable Power of Attorney for Health Care.***

J. ***If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.***

1. **Designation of Health Care Agent:**

I, _____ do hereby designate and appoint _____, Telephone Number _____, as my Agent to make health care decisions for me as authorized in this document. Unless my Agent is also my spouse, my legal guardian, or the person most closely related to me by blood, none of the following may be designated as my Agent: (a) a treating provider of my health care; (b) an employee of a treating provider of my health care; (c) an operator of a health care facility; or (d) an employee of an operator 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 Provisions 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 agent's 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. ***(Initial here if there are no other limitations: _____)***

5. **Duration:**

I understand 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 Agent will continue to exist until the time when I become able to make health care decisions for myself.

I wish to have this power of attorney end on the following date: _____ ***(Initial here if indefinite: _____)***

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 unkonwn, you 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 blank next to the statement):**

6.1 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. _____

6.2 If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. ***(NOTE: If initialed, provisions of NRS 449.535 to 449.690, inclusive, apply.)*** _____

6.3 If I have an incurable or terminal condition or illness and no reasonable hope of my long term recovery or survival, I desire life-sustaining or prolonging treatments not be used. ***(NOTE: If initialed, provisions of NRS 449.535 to 449.690, inclusive, apply.)*** _____

6.4 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. _____

6.5 I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My Agent 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. _____

6.6 Input any special desires, if any:

7. **Designation of Alternate Agent:**

You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 2, 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:

FIRST ALTERNATE AGENT:	**Name:** **Ph. #:**

8. Prior Designations Revoked:

I revoke any prior Durable Power of Attorney for Health Care.

9. 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.

10. Challenges:

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, 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. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

11. 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.

BEFORE THIS POWER IS VALID, YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY, AND IT MUST BE ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I sign my name to this Durable Power of Attorney for Health Care on _____, at Las Vegas, Nevada.

_____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF NEVADA }
} ss.
COUNTY OF CLARK }

On this _____ day of _____, before me, a Notary Public in and for said County and State, personally appeared _____ 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/she executed it. I declare under penalties of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____

NOTARY PUBLIC

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 community care facility, nor an employee of an operator of a health care facility.

Witness Signature	Witness Signature
Print Name	Print Name
Address	Address
Date	Date

At least one of the 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 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.

Witness Signature	Witness Signature
Print Name	Print Name
Address	Address
Date	Date