

NEBRASKA LIVING WILL AND POWER OF ATTORNEY FOR HEALTH CARE

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. Other directions: I appoint, _____ whose address is _____ and whose telephone number is _____ as my attorney in fact for health care. as my successor 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 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 attorney in fact comply with the following instructions or limitations: I direct that my attorney in fact comply with the following instructions on life-sustaining treatment: (optional) I direct that my attorney in fact comply with the following instructions on artificially

administered nutrition and hydration: (optional)



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 INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Signature of person making de	signation/date)		
DECLARATION OF WITNES We declare that the princip acknowledged his or her signa the principal appears to be of neither of us nor the principal's this document. Witnessed By:	oal is personally known ture on this power of attorn sound mind and not under	ey for heal or duress o	Ith care in our presence, that or undue influence, and that
(Signature of Witness/Date)		(Printed 1	Name of Witness)
(Signature of Witness/Date) OR State of Nebraska)		(Printed I	Name of Witness)
On this	lay of	_, 2	_, before me, County,
personally came identical person whose name principal, and I declare that h influence, that he or she ackno and deed, and that I am not th power of attorney for health ca	is affixed to the above pare or she appears in sound owledges the execution of the attorney in fact or successive.	_ personal power of mind and he same to ssor attorne	ly to me known to be the attorney for health care as not under duress or undue to be his or her voluntary act
Seal Signatur	re of Notary Public	_	