Power of Attorney for Health Care

(Nebraska Revised Statutes §§ 30-3401 to 30-3432)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint an attorney in fact in case of my incapacity.

2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.

3. **Regarding end-of-life matters:** [initial one of the two choices]

   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.

4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

   _____

   _____

   _____

   _____

   _____

   _____

5. I give no one (including my attorney in fact) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.

6. Apart from the matters covered above, I appoint the person named herein as my attorney in fact to make health-care decisions for me. I give my attorney in fact full power and authority to consent to or to refuse treatment (including the providing, withholding, or withdrawing of life-sustaining procedures and artificially administered nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed attorney in fact is unavailable, unable, or unwilling to serve, I appoint a successor attorney in fact herein to serve with the same power and authority.

7. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my attorney in fact fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my attorney in fact has the authority to make health-care decisions for me even while I am pregnant.

8. 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*) (Date)

_____

(Address)

DECLARATION OF WITNESSES: We declare that the principal (the person who signed above) 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 attorney in fact or successor attorney in fact by this document.** Furthermore, we are not the principal's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of this witnessing, attending physician, nor an employee of the principal's life- or health-insurance provider. At least one of us is not an administrator or employee of the principal's treating health-care provider.

_____ _____

(Signature of witness) (Signature of witness)

_____ _____

(Address) (Address)

ATTORNEY IN FACT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

SUCCESSOR ATTORNEY IN FACT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

* **Note:** Before signing this document fill out the entire document (including the names, addresses, and telephone numbers of your attorneys in fact). You should sign this document in the presence of two witnesses. You may appoint any adult who is 19 years of age or older to be your attorney in fact except (1) your attending physician, (2) a nonrelative employee of your attending physician, (3) a nonrelative owner, operator, or employee of a health-care provider in or of which you are a patient or a resident, or (4) a nonrelative person who, at the time of the proposed appointment, is presently serving as an attorney in fact for ten or more principals. A "nonrelative" is a person not related to you by blood, marriage, or adoption.

Power of Attorney for Health Care

(signed document inside)

NO BLOOD