Durable Power of Attorney for Health Care Decisions

(Nevada Revised Statutes §§ 162A.700 to 162A.860)

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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

10. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

Durable Power of Attorney for Health Care Decisions

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent 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 agent) 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 agent to make health-care decisions for me. I give my agent full power and authority to consent to or to refuse treatment (including artificial 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 agent is unavailable, unable, or unwilling to serve, I appoint an alternate agent herein to serve with the same power and authority. I sign my name to this Durable Power of Attorney for Health Care Decisions on the date indicated below.

_____ _____

(Signature*) (Date)

_____

(Address)

STATEMENT OF WITNESSES: [Note: You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the health-care agent or alternate agent, (2) a provider of health care, (3) an employee of a provider of health care, (4) the operator of a health-care facility, or (5) an employee of an operator of a health-care facility. At least one of the witnesses must be a nonrelative of the principal and must make the additional declaration set out following the place where the witnesses sign.]

I declare under penalty of perjury that the principal (the person who signed on page 3) is personally known to me, that the principal signed or acknowledged this Durable Power of Attorney for Health Care Decisions in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that **I am <u>not</u> the person appointed as health-care agent or alternate 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 health-care facility, or an employee of an operator of a health-care facility.

(Signature of witness / Date)	(Signature of witness / Date)
(Address)	(Address)

AT LEAST ONE OF THE ABOVE 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 that 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.

(Signature / Date)	(Signature / Date)

HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

*** Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care agents). You should sign this document in the presence of two witnesses. You may appoint any adult to be your agent <u>except</u> (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3) an operator of a health-care facility, or (4) an employee of a health-care facility, unless the person is also your spouse, legal guardian, or next of kin.

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(signed document inside)

NO BLOOD