

**NEVADA  
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS**

**WARNING TO PERSONS 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 ATTORNEY-IN-FACT 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.

**1. DESIGNATION OF HEALTH CARE AGENT.**

I, \_\_\_\_\_ (insert your name), do hereby designate and appoint:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decision for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (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 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 attorney-in-fact 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, subject only to the limitations and special provision, if any, set forth in paragraph 4 or 6.

**4. SPECIAL PROVISIONS AND LIMITATIONS.**

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psycho surgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact 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.)

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

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**5. DURATION.**

I understand that 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 attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this power of attorney end on the following

date: \_\_\_\_\_.

**6. STATEMENT OF DESIRES.**

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact 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 unknown, your attorney-in-fact 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 BOX NEXT TO THE STATEMENT.)**

(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. [\_\_\_\_\_]

(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. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.) [\_\_\_\_\_]

(3) If I have an incurable or terminal condition or illness and no reasonable hope of long term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.) [\_\_\_\_\_]

(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. [\_\_\_\_\_]

(5) Except as set forth in Paragraph (2) and/or (3) above, I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact 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) I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact 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. [\_\_\_\_\_]

(7) If any of my tissues or organs are sound and would be of value, I freely give my permission for such donation pursuant to the

Uniform Anatomical Gift Act (NRS 451.500) for the following purposes:

- (a) For transplant to other people. [\_\_\_\_\_]
- (b) For transplant to family, only. [\_\_\_\_\_]
- (c) For medical research. [\_\_\_\_\_]

(8) I want the financial cost of my medical treatment to be taken into account and weighed against the likelihood that the treatment will achieve the goals that I have initialed above. [\_\_\_\_\_]

(9) If I am disabled, but not in need of nursing home care, then I direct my attorney-in-fact to obtain an individualized care plan for me which is to be prepared by a geriatric care manager within 60 days of my disability. In making said plan, I direct that the plan be developed in a manner so that I can be maintained in the least restrictive environment. [\_\_\_\_\_]

(10) If a guardian is appointed of my person and/or estate, by a court of competent jurisdiction, then I direct my attorney-in-fact to submit this Durable Power of Attorney for Health Care Decisions to said court. I then request that said court implement my directives contained herein and that the court direct, by its order, that my designated attorney-in-fact is to continue to make my health care and placement decisions in accordance with this document, even if my attorney-in-fact is not a Nevada resident. [\_\_\_\_\_]

(11) If I am diagnosed as having dementia or the Alzheimer's type or other dementia that is deemed by best available medical knowledge to be progressive and irreversible, and I no longer have decision-making capacity, I desire that I be allowed to die of natural causes such as pneumonia or dehydration if I become ill or fail to take in enough fluids by mouth. [\_\_\_\_\_]

(12) It is my desire to be comfortable. If I cannot communicate with my Doctor, family or friends, then I want my Attorney-in-fact, family and friends to know the following:

(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. When the circumstances are appropriate, and in accordance with my wishes as I have expressed them, such pain relief may be authorized even though its use may lead to physical damage, addiction, or even hasten the moment of (but not intentionally cause) my death. [\_\_\_\_\_]

(b) If my temperature is above normal, I want a cool moist cloth put on my head. [\_\_\_\_\_]

(c) I want my mouth and lips kept moist. [\_\_\_\_\_]

(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower. [\_\_\_\_\_]

(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort. [\_\_\_\_\_]

(f) I want to have my favorite types of music played when possible. [\_\_\_\_\_]

(g) I want my personal care such as nail clipping, hair combing, and teeth brushing and shaving as long as they do

not cause me pain. [\_\_\_\_\_]

(h) I want to have religious readings read to me when I am near death. [\_\_\_\_\_]

(i) I want to have my favorite poems read to me from time to time. [\_\_\_\_\_]

(j) Please arrange for family pictures to be placed in my room. [\_\_\_\_\_]

(13) I hope my family and friends would consider that:

(a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent. [\_\_\_\_\_]

(b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand. [\_\_\_\_\_]

(c) Please don't be afraid to hold my hand or hug me. [\_\_\_\_\_]

(d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me. [\_\_\_\_\_]

(e) Please maintain a cheerful atmosphere around me. [\_\_\_\_\_]

(f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day. [\_\_\_\_\_]

(g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled. [\_\_\_\_\_]

(h) If at all possible, allow me to die in my home. [\_\_\_\_\_]

(i) Please arrange for me to watch on television, or listen to my favorite sports events. [\_\_\_\_\_]

(j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me. [\_\_\_\_\_]

(14) I want my care to be provided in a manner that promotes palliative care as set forth on Attachment 1. [\_\_\_\_\_]

**OTHER OR ADDITIONAL STATEMENTS OF DESIRES:**

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\_\_\_\_\_  
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\_\_\_\_\_  
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7. It is my intention that this instrument serve both as a self-executing document and as a delegation of power to my attorney-in-fact. This document shall be deemed an exercise of all rights that I may have under the United States Constitution, the Constitution of Nevada, and any other relevant state and federal laws, rules, regulations and decisions, to refuse medical treatment.

8. I desire that my wishes be carried out through the authority given to my attorney-in-fact by this document despite any contrary feelings, beliefs or opinions of other members of my family, relatives or friends.

9. I realize that the situations described in this document are subject to various interpretations, and I am confident that the person(s) named as my attorney-in-fact will exercise the judgment that I myself would exercise if competent.

10. If my attorney-in-fact or my alternate attorney(s) in fact is unavailable, I nevertheless request that my instructions and preferences in this document be observed.

**11. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT.**

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you

designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-fact

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

B. Second Alternative Attorney-in-fact

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

**12. PRIOR DESIGNATIONS REVOKED.**

I revoke any prior durable power of attorney for health care. However, this shall not be construed as a revocation of any durable power of attorney I may have made for the management of my business and/or personal affairs.

**13. WAIVER OF CONFLICT OF INTEREST.**

If my designated attorney-in-fact or if any alternate designated attorney-in-fact is my spouse or is one of my children then in that event I waive any conflict of interest that said spouse or child may have in carrying out the provisions of this Durable Power of Attorney for Health Care, by reason of the fact that said

spouse or child may be a recipient of my estate whether by Will, the laws of intestate succession or pursuant to a Trust or other arrangement.

**(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)**

I sign my name to this Durable Power of Attorney For Health Care on:

\_\_\_\_\_, 200\_\_ at \_\_\_\_\_  
(date) (city and state)

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Town, State, Zip: \_\_\_\_\_

Telephone number: (\_\_\_\_\_) \_\_\_\_\_

Social Security number: \_\_\_\_\_

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE, OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

**CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC**

STATE OF NEVADA )  
 ) ss.  
COUNTY OF WASHOE )

On this \_\_\_\_ day of \_\_\_\_\_, in the year 200\_\_, before me, \_\_\_\_\_, (here insert name of Notary Public) personally appeared \_\_\_\_\_, (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who executed the above instrument, and acknowledged to me that he or she executed the same for purposes stated therein. I declare under penalty 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 in and for said  
County and State.

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.