Nevada Living Will Declaration

NRS § 449.610

If I should 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 *NRS 449.535 to 449.690*, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include this statement in this declaration, you must INITIAL the statement in the box provided:

[_____]

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld pursuant to this declaration.

[_____]

Signed this _____ day of _____, _____.

Signature _____

Address _____

_____

The declarant voluntarily signed this writing in my presence.

Witness _____

Address _____

_____

Witness _____

Address _____

_____

Nevada Durable Power of Attorney for Healthcare

1. DESIGNATION OF HEALTHCARE AGENT.
I, _____, do hereby designate and appoint:
(name)
NAME: _____
ADDRESS: _____
TELEPHONE NUMBER: _____
as my attorney-in-fact to make healthcare decisions for me as authorized in this document.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTHCARE.
By this document I intend to create a durable power of attorney by appointing the person designated above to make healthcare 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 healthcare decisions , I hereby grant to the attorney-in-fact named above full power and authority to make healthcare 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 provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISION 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, psychosurgery, 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 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 healthcare 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 healthcare, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 on the following page.)
(If the statement reflects your desires, initial the line 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.
Initial _____
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.
Initial _____
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.
Initial _____
4. I direct my attending physician **not** to withhold or withdraw artificial nutrition and hydration by way of the gastro-intestinal tract if

such a withholding or withdrawal would result in my death by starvation or dehydration.
Initial _____
5. 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.
Initial _____
Other or Additional Statements of Desires:

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT.
If the person designated in paragraph 1 as my attorney-in-fact is unable to make healthcare decisions for me, then I designate the following persons to serve as my attorney-in-fact to make healthcare 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: _____

Telephone Number: _____

B. Second Alternative Attorney-in-fact
Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED.
I revoke any prior durable power of attorney for healthcare.
(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to t his Durable Power of Attorney for Healthcare on
_____ at _____, _____.
(date) *(city)* *(state)*

_____
(signature)
(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTHCARE 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
(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of Nevada)
) ss.
County of _____)

On this _____ day of _____, in the year _____, before me, _____, personally appeared
(name of notary public)

_____
(name of principal)
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 or she executed it. 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 SEAL

_____
(signature of notary public)

OR

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 attorney-in-fact by this document, and that I am not a provider of healthcare, an employee of a provider of healthcare, the operator of a community care facility, nor an employee of an operator of a healthcare facility.

Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

Signature: _____

Print Name: _____

Date: _____

Residence 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 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: _____

Print Name: _____

Date: _____

Residence Address: _____

Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

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 healthcare.