NEVADA

ADVANCE DIRECTIVES

Legal Documents
To Assure Future Health Care Choices

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS UNDER THE LAW IN NEVADA

INTRODUCTION

Nevada and federal law give every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatment or you wish to name someone to make health care decisions for you, you have the right to make these desires known to your doctor, hospital or other health care providers, and in general, have these rights respected. You also have the right to be told about the nature of your illness in terms that you can understand the general nature of the proposed treatments, the risk of failing to undergo these treatments and any alternative treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to you.

However, these may be times when you cannot make your wishes known to your doctor or other health care providers. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know what your specific wishes are about the medical care that you want or do you not want to receive.

This booklet describes what Nevada and federal law have to say about your right to inform your health care providers about medical care and treatment you want or do not want, and about your right to select another person to make these decisions for you, if you are physically or mentally unable to make them yourself.

To make these difficult issues easier to understand, we have presented the information in the form of questions and answers. Because this is a very important matter, we urge you to talk to your spouse, family, close friends, personal advisor, your doctor and your attorney before deciding whether or not you want an advance directive.

QUESTIONS AND ANSWERS

GENERAL INFORMATION ABOUT ADVANCE DIRECTIVES

What are "Advance Directives"?

Advance Directives are documents which state your choices about medical treatment or name someone to make decisions about your medical treatment, if you are unable to make these decisions or choices yourself. They are called "advance" directives, because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives you can make legally valid decisions about your future medical care.

Nevada law recognizes 3 types of advance directives:

1. A Living Will Declaration.
2. A Durable Power of Attorney for Health Care.
3. A Durable Power of Attorney for Health Care Decisions for Adults with Intellectual Disabilities.

Do I have to have an Advance Directive?

No, it is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatment that you want or do not want, advance directives may help to solve these important issues. Your doctor or any health care provider cannot require you to have an advance directive in order to receive care; nor can they prohibit you from having an advance directive. Moreover, under Nevada law no health care provider or insurer can charge a different fee or rate depending on whether or not you have executed an advance directive.

What will happen if I do not make an Advance Directive?

You will receive medical care even if you do not have any advance directives. However, there is a greater chance that you will receive more treatment or more procedures than you may want.

If you cannot speak for yourself and you do not have any advance directives, your doctor or other health care providers will look to the following people in the order listed for decisions about your care: 1. Your spouse; 2. An adult child, or if you have more than one adult child, a majority of those children who are reasonable available for consultation; 3. Either of your parents; 4. An adult brother or sister, or if you have more than one, a majority of those who are reasonable available for consultation; 5. Your nearest other adult relative by blood or adoption who is reasonable available for consultation.

How do I know what treatment I want?

Your doctor must inform you about your medical condition and what different treatments can do for you. Many treatments have serious side effects. Your doctor must give you information, in language that you can understand, about serious problems that medical treatment is likely to cause. Often, more than one treatment might help you and different people might have different ideas on which is best. Your doctor can tell you the treatments that are available to you, but he cannot choose for you. That choice depends on what is important to you.

Whom should I talk to about Advance Directives?

Before writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends and other appropriate people, such as a member of your clergy or your lawyer. These are the people who will be involved with your health care, if you are unable to make your own decisions.

When do Advance Directives go into effect?

It is important to remember that these directives only take effect when you can no longer make your own health care decisions. As long as you are able to give "informed consent", your health care providers will rely on **YOU** and **NOT** on your advance directives.

What is "Informed Consent"?

Informed consent means that you are able to understand the nature, extent and probable consequences of proposed medical treatments and you are able to make rational evaluations of the risks and benefits of those treatments as compared with the risks and benefits of alternate procedures **AND** you are able to communicate that understanding in any way.

How will health care providers known if I have any Advance Directives?

All hospitals, nursing homes, home health agencies, HMOs and all other health care facilities that accept federal funds must ask if you have an advance directive, and if so, they must see that it is made part of your medical records.

Will my Advance Directives be followed?

Generally, yes, if they comply with Nevada law. Federal law requires that your health care providers give you their written policies concerning advance directives. A summary statement of those policies is provided for you at the back of this book. It may happen that your doctor or other health care provider cannot or will not follow your advance directives for moral, religious or professional reasons, even though they comply with Nevada law. If this happens, they must immediately tell you. Then they must help you transfer to another doctor or facility that will do what you want.

Can I change my mind after I write an Advance Directive?

Yes. At any time, you can cancel or change any advance directive that you have written. To cancel your directive, simply destroy the original document and tell your family, friends, doctor and anyone else who has copies that you have cancelled them. To change your advance directives, simply write and date a new one. Again, give copies of your documents to all the appropriate parties, including your doctor.

Do I need a lawyer to help me make an Advance Directive?

A lawyer may be helpful and you might choose to discuss these matters with him or her,. But there is no legal requirement in Nevada to do so. You may use the forms that are provided in this booklet to execute your advance directives.

Will my Nevada Advance Directive be honored in another state?

The laws on advance directives differ from state to state, so it is unclear whether a Nevada advance directive will be honored in another state. Because an advance directive is a clear expression of your wishes about medical care, it will influence that care no matter where you are admitted. However, if you plan to spend a great deal of time in another state, you might consider signing an advance directive that meets all the legal requirements of that state.

Will an Advance Directive from another state be honored in Nevada?

Yes. An advance directive executed in compliance with another state's laws will be honored in Nevada to the extent permitted by Nevada law.

What should I do with my Advance Directives?

You should keep them in a safe place where your family members can get to them. Do **NOT** keep the original copies in your safe deposit box. Give copies of these documents to as many of the following people as you are comfortable with: your spouse and other family members; your doctor; your lawyer; your clergyperson; and any local hospital or nursing home where you may be resting. Another idea is to keep a small called card in your purse or wallet which states that you have an advance directive and who should be contacted. Wallet cards are provided for you at the back of this booklet for that purpose.

DECLARATION (LIVING WILL)

What is a "Living Will"?

A living will (officially called a "Declaration" in Nevada) is a document which tells your doctor or other health care providers whether or not you want life-sustaining treatments or procedures administered to you if you are in a terminal condition. It is called a "living will" because it takes effect while you are still living.

Is a "Living Will" the same as a "Will" or "living Trust"?

No. Wills and living trusts are financial documents which allow you to plan for the distribution of your financial assets and property after your death. A living will only deals with medical issues while you are still living. Wills and living trusts are complex legal documents and you usually need legal advice to execute them. You do not need a lawyer to complete you Nevada living will.

When does a Nevada Living Will go into effect?

A Nevada living will goes into effect when: 1. your doctor has a copy of it, and 2. your doctor has concluded that you are no longer able to make your own health care decisions, and 3. your doctor has determined that you are in a terminal condition.

What are "life sustaining" treatments?

These are treatments or procedures that are not expected to cure your terminal condition or make you better. They only prolong dying. Examples are mechanical respirators which help you breathe, kidney dialysis which clears your body of wastes, and cardiopulmonary resuscitation (CPR) which restores your heartbeat.

What is a "terminal" condition?

A terminal condition is defined as an incurable for which administration of medical treatment will only prolong the dying process and without administration of these treatments or procedures, death will occur in a short period of time.

Is a Living Will the same as a "Do Not Resuscitate (DNR)" order?

No. A Nevada living will covers almost all types of life-sustaining treatments and procedures. A "Do Not Resuscitate" order covers 2 types of life-threatening situations. A DNR order is a document prepared by your doctor at your direction and placed in your medical records. It states that if you suffer cardiac arrest (your heart stops beating) or respiratory arrest (you stop breathing), your health care providers are not to try to revive you by any means.

Will I receive medication for pain?

Unless you state otherwise in the living will, medication for pain will be provided where appropriate to make you comfortable and will not be discontinued.

Does a Nevada Living Will apply if a woman is pregnant?

Nevada law is very specific on this subject. The living will cannot go into effect if a woman is pregnant and it is probable that the child will develop to the point of live birth with the continued application of life-sustaining treatments.

Does a Nevada Living Will affect insurance?

No. The making of a living will, in accordance with Nevada law, will not affect the sale or issuance of any life insurance policy, nor shall it invalidate or change the terms of any insurance policy. In addition, the removal or life-support systems according to Nevada law, shall not, for any purpose, constitute suicide, homicide or euthanasia, nor shall it be deemed the cause of death for the purposes of insurance coverage.

Does a Nevada Living Will have to be signed and witnessed?

Yes. You must sign (or have someone sign the document in your presence and at your direction, if you are unable to sign) and date the living will. Then it must be witnessed by 2 adult people.

Unlike many states, Nevada does not put any restrictions on who can witness your signature of the living will. However, it is recommended that the following people **SHOULD NOT** serve as witnesses: 1. Your attending physician or an employee of your attending physician; 2. Anyone related to you by blood, marriage or adoption; 3. Anyone who is entitled to any part of your estate upon your death; 4. Anyone who has a claim against any portion of your estate; or 5. Any person directly financially responsible for your medical care.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

What is a Durable Power of Attorney for Health Care (DPAHC)?

A DPAHC is a legal document which allows you (the "principal") to appoint another person (the "agent" or "attorney-in-fact") to make medical decisions for you if you should become temporarily or permanently unable to make those decisions yourself. The person you choose as your attorney-in-fact does not have to be a lawyer.

Who can I select to be my Agent?

You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knowns how you feel about health care. You should discuss the matter with the person (s) you have chosen and make sure that they understand and agree to accept the responsibility.

You can select a member of your family, such as your spouse, child, brother or sister, or a close friend. If you select your spouse and then become divorced, the appointment of your spouse as your agent is revoked.

The following people **CANNOT** be appointed as you agent, unless they are your spouse, your legal guardian or your next of kin: 1. Your treating health care provider; 2. An employee of your treating health care provider; 3. An operator of a health care facility; 4. An employee of an operator of a health care facility.

When does the DPAHC take effect?

The DPAHC only becomes effective when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making those decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are able to make treatment decisions, you have the right to do so.

What decisions can my Agent make?

Unless you limit his/her authority in the DPAHC, your agent will be able to make almost every treatment decision in accordance with accepted medical practice that you could make, if you were able to do so. If you wishes are not known or cannot be determined, your agent has the duty to act in your best interest in the performance of his/her duties. These decisions can include authorizing, refusing or withdrawing treatment, even it if means that you will die. As you can see, the appointment of an agent is a very serious decision on your part.

Are there any decisions my Agent cannot make?

Yes. Nevada law prohibits your agent from consenting to: 1. Committing or placing you in a facility for treatment of mental illness; 2. Abortion; 3. Psychosurgery; 4. Convulsive treatment; or 5. Sterilization.

What happens if I regain the capacity to make my own decisions?

If your doctor determines that you have regained the capacity to make or to communicate health care decisions, then two things will happen: 1. Your agent's authority will end; and 2. Your consent will be required for treatment.

If your doctor later determines that you no longer have the capacity to make or to communicate health care decisions, then your agent's authority will be restored.

Can there be more than one Agent?

Yes. While you are not required to do so, you may designate alternates who may also act for you, if your primary agent is unavailable, unable or unwilling to act. Your alternates have the same decision-making powers as the primary agent.

Can I appoint more than one person to share the responsibility of being my Agent?

You should appoint only **ONE** person to be your primary Agent. Any others that you want to be involved with your health care decisions should be appointed as your alternates. If two or more people are given equal authority and they disagree on a health care decision, one of the most important purposes of the DPAHC—to clearly identify who has the authority to speak for you—will be defeated. If you are afraid of offending people close to you by choosing one over another to be your agent, ask them to decide among themselves who will be your primary agent and select the others as alternates.

Can my Agent resign?

Yes. Your agent and your alternatives can resign at any time by giving written notice to you, your doctor or the hospital or nursing home where you are receiving care.

Does the DPAHC have to be signed and witnessed?

Yes. You must sign (or have someone sign the DPAHC in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by 2 qualified people or notarized.

The following people **CANNOT** witness your signature of the DPAHC:

1. The person you appointed as your agent;
2. A health care provider;
3. An employee of a health care provider;
4. An operator of a health care facility;
5. An employee of an operator of a health care facility.

In addition, at least one of the two witnesses must not be related to you by blood, marriage or adoption or entitled to any part of your estate upon your death.

How is the DPAHC different from the Living Will?

A living will only applies if you are terminally ill and unless you write in other specific instructions, it only tells your doctor when you do **NOT** want.

The DPAHC allows you to appoint someone to make health care decisions for you if you cannot make them. It covers all health care situations in which you are incapable of making decisions for yourself. It also allows you to give specific instructions to your agent about the type of care you want to receive.

The DPAHC allows your Agent to respond to medical situations that you might not have anticipated and to make decisions for you with knowledge of your values and wishes.

Since the DPAHC is more flexible, it is the advance directive more people choose. Some people, however, do not have someone whom they trust or who knows their values and preferences. These people should consider creating a living will.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS FOR ADULTS WITH INTELLECTUAL DISABILITIES (DPAHCDAID)

What is a Durable Power of Attorney for Health Care Decisions for Adults with Intellectual Disabilities (DPAHCDAID)?

A DPAHCDAID is a legal document which allows you (the “principal”) to appoint another person (the “agent” or “attorney-in-fact”) to make medical decisions for you if you should become temporarily or permanently unable to make those decisions yourself and you have intellectual disabilities. The person you choose as your attorney-in-fact does not have to be a lawyer.

Who can I select to be my Agent?

You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knows how you feel about health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

What decisions can my Agent make?

Unless you limit his/her authority in the DPAHCDAID, you agent will be able to make almost every treatment decision in accordance with accepted medical practice that you could make, if you were able to do so. If your wishes are not known or cannot be determined, your agent has the duty to act in your best interest in the performance of his/her duties. These decisions can include authorizing, refusing or withdrawing treatment, even it if means that you will die. As you can see, the appointment of an agent is a very serious decision on your part.

Does the DPAHCDAID have to be signed and witnessed?

Yes. You must sign (or have someone sign the DPAHCDAID in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by 2 qualified people or notarized. The following people **CANNOT** witness your signature of the DPAHCDAID: 1.The person you appointed as your agent; 2. A health care provider; 3. An employee of a health care provider; 4. An operator of a health care facility; 5. An employee of an operator of a health care facility. In addition, at least one of the two witnesses must not be related to you by blood, marriage or adoption or entitled to any part of your estate upon your death.

Where can I get a Nevada DPAHCDAID document?

Because of space limitations, the DPAHCDAID document suggested by Nevada law has not been provided in this booklet. You should contact your doctor or other health care provider to get a copy of the suggested document, or you can purchase the suggested document by visiting our website at www.advdir.com and the document (available in English only) will be mailed to you.

NEVADA DURABLE POWER OF ATTORNEY

FOR HEALTH CARE DECISIONS
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 other 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, the power will exist indefinitely from the date you execute this document and, if you are unable to make healthcare 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 your 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, _____ do here by designate and appoint:
Name: _____ Phone No: _____
Address: _____
City, State, Zip Code: _____
as my agent 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 agent to make health care decisions 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 agent: 1. your treating provider of health care; 2. an employee of our 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 agent 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; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required to obtain medical care and/ or medical and hospital records, **EXCEPT** any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your agent 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 agent's authority to give consent for or other restrictions you wish to place on his or her agent's authority, you should list them in the space below.

If you do not write any limitations, your agent 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 agent 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 health care decisions for myself when this power of attorney expires, the authority I have granted my agent 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 agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If you desires are unknown, your agent 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, or the chances I have for recovery or long-term survival, or the cost of the procedures. ☐

2. If I am in a coma with my doctors have reasonable 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 also 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 gastrointestinal tract after all other treatment is withheld.

5. I do not desire treatment to be provided and/ or continued if the burdens of the treatment outweigh the expected benefits. My agent is to consider the relief of suffering, preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

   (If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want and circling the answer you prefer.)

Other or Additional Statements of Desires:

_____

_____

7. DESIGNATION OF ALTERNATE AGENT

(You are not required to designate any alternative agent, but may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

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

A. FIRST ALTERNATIVE AGENT

Name: _____

Address: _____

Telephone Number: _____

B. SECOND ALTERNATIVE AGENT

Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

9. WAIVER OF CONFLICT OF INTEREST

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the face that he or she may be a beneficiary of my estate.

10 . CHALLENGES

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, my agent or a third party, and then my agent it authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

11. NOMINATION OF GUARDIAN

If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent(s) herein named, in the order named above.

12. RELEASE OF INFORMATION

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended and applicable regulations.

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

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

Date: _____ at (City):_____ State: _____

Signature: _____

(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 personal known to you and who are present when you sign or acknowledge your signature or 2. acknowledged before a notary public.)

CERTIFICATE OF ACKNOWLEDGEMENT 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, _____(here inset the name of notary public) 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.

Signature of Notary Public:

_____

Notary Seal

-OR-

STATEMENT OF WITNESES

(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 agent; 2. a provider of health care; 3. an employee of a provider of health care; 4. the operator of a health care facility; 5. an

employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign).

I declare under penalty of perjury that the principal is personal 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 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: _____ Date: _____

Address: _____

City, State, Zip Code: _____

Signature: _____ Date: _____

Address: _____

City, State, Zip Code: _____

ONE OF THE ABOVE WITNESSES MUST 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 or the principal upon the death of the principal under a will now existing or by
operation of law.

Signature: _____

Signature: _____

NEVADA LIVING WILL DECLARATION

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 appoint _____ or, if he or she is not reasonably available or is unwilling to serve, _____, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviated pain, pursuant to NRS 449.535 to 449.690, inclusive. (If the person or persons I have so appointed are not reasonable available or are unwilling to serve, I direct my attending physician, pursuant to those sections, to withhold or withdraw treatment that only prolongs the process of dying and it not necessary for my comfort or to alleviate pain.)

Strike language in parentheses if you do not desire it.

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 gastrointestinal tract after all other treatment is withheld pursuant to this declaration.

SIGNATURE OF DECLARANT

Signed this _____ day of _____, 20_____
Signature of Declarant: _____
Address: _____
City, State, Zip Code: _____

SIGNATURE OF WITNESSES

The declarant voluntarily signed this writing in my presence.
Witness Signature: _____
Address: _____
City, State, Zip Code: _____

Witness Signature: _____
Address: _____
City, State, Zip Code: _____

A Summary Statement of Health Care Policies Regarding Patients' Rights of Self-Determination

(Since a summary like this cannot answer all possible questions or cover every circumstance, you should discuss any remaining questions with a representative of this health care facility.)

1. Prior to the start of any procedure or treatment, the physician shall provide the patient with whatever information is necessary for the patient to make an informed judgment about whether the patient does or does not want the procedure or treatment performed. Except in an emergency, the information provided to the patient to obtain the patient's consent shall include, but not necessarily be limited to, the intended procedure or treatment, the potential risks and the probable length of disability. Whatever significant alternatives of care or treatment exist, or when the patient requests information concerning alternatives, the patient shall be given such information. The patient shall have the right to know the person responsible for all procedures and treatments.

2. The patient may refuse medical treatment to the extent permitted by law. If the patient refuses this treatment, the patient will be informed of the significant medical consequences that may result from such action.

3. The patient will receive written information and the opportunity concerning his or her individual rights under Nevada state law to make decisions concerning medical care.

4. The patient will be given information and the opportunity to make advance directives—including, but not limited to, an Nevada Living Will Declaration, a Durable Power of Attorney for Health Care and a Durable Power of Attorney for Health Care Decisions for Adults with Intellectual Disabilities.

5. The patient shall receive care regardless of whether or not the patient has or has not made an advance directive.

6. The patient shall have his or her advance directive(s), if any has been created, made a part of his or her permanent medical record.

7. The patient shall have all of the terms of his or her advance directive(s) complied with by the health care facility and caregivers to the extent required or allowed by Nevada law.

8. The patient shall be transferred to another doctor or health care facility if his or her doctor(s), or agent of his or her doctor(s), or the health care facility cannot respect the patient's advance directive requests as a matter of "conscience".

9. The patient shall receive the name, phone number and address of the appropriate state agency responsible for receiving questions and complaints about these advance directive policies.

WALLET CARDS FOR NEVADA ADVANCE DIRECTIVES

Complete and cut out the card below. Put the cards in the wallet or purse you carry most often, along with your driver's license or health insurance card.

ATTN: NEVADA HEALTH CARE PROVIDERS

_____

(Your Name)

I have created the following **Advanced Directives:**

(Check one or more)

_____ **Nevada Living Will Declaration**
_____ **Durable Power of Attorney for Health Care**
_____ **Durable Power of Attorney for Heath Care Decisions for Adults with Intellectual Disabilities**

Please contact _____

(Name)

at _____ for more information.

(Telephone Number)

ATTN: NEVADA HEALTH CARE PROVIDERS

_____

(Your Name)

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