Nebraska Power of Attorney

Health Care

POWER OF ATTORNEY FOR HEALTH CARE

I,_____(your name) name the following person as my attorney in fact for health care:

Name: _____

Address: _____

Phone Number: _____

SUCCESSOR TO POWER OF ATTORNEY FOR HEALTH CARE

If my agent (above) is unwilling or unable to act, I appoint the following person as my successor power of attorney for health care:

Name: _____

Address: _____

Phone number: _____

By initialing the below, I acknowledge that I have read and understand each statement and the consequences of executing a power of attorney for health care.

____ I authorize my attorney in fact for health care appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions

____ I direct that my attorney in fact for health care comply with the following instructions or limitations:

_____

_____

_____

_____

____ I direct that my attorney in fact for health care comply with the following instructions on life-sustaining treatment: (*optional*)
limitations:

_____
_____
_____
_____

____ I direct that my attorney in fact for health care comply with the following instructions on artificially administered nutrition and hydration: (*optional*)

_____
_____
_____
_____

____ **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 for health care, 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.**

____ **I have read the above warning which accompanies this document and understand the consequences of executing a power of attorney for health care.**

_____ _____

Signature of person making designation *Date*

Do not sign this form until you are in the presence of either the two witnesses or a notary.

DECLARATION OF WITNESSES

We declare that the individual signing this power of attorney for health care is personally known to us, has signed or acknowledged his or her signature on this power of attorney for health care in our presence, and appears to be of sound mind and not under duress or undue influence. Furthermore, neither of us, nor the principal's attending physician, is the person appointed as attorney in fact for health care by this document.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

OR

NOTARY

State of Nebraska)
) ss.
[County] of _____)

This document was acknowledged before me on _____
(Date)

by _____.
(Name of Principal)

_____ (Seal, if any)
Signature of Notary

My commission expires: _____