# DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

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**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 DECIDE WHERE YOU LIVE, EVEN AS YOU AGE. DECISIONS ABOUT WHERE YOU LIVE ARE PERSONAL. SOME PEOPLE LIVE AT HOME WITH SUPPORT, WHILE OTHERS MOVE TO ASSISTED LIVING FACILITIES OR FACILITIES FOR SKILLED NURSING. IN SOME CASES, PEOPLE ARE MOVED TO FACILITIES WITH LOCKED DOORS TO PREVENT PEOPLE

WITH COGNITIVE DISORDERS FROM LEAVING OR GETTING LOST OR TO PROVIDE ASSISTANCE TO PEOPLE WHO REQUIRE A HIGHER LEVEL OF CARE. YOU SHOULD DISCUSS WITH THE PERSON DESIGNATED IN THIS DOCUMENT YOUR DESIRES ABOUT WHERE YOU LIVE AS YOU AGE OR IF YOUR HEALTH DECLINES. YOU HAVE THE RIGHT TO DETERMINE WHETHER TO AUTHORIZE THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE DECISIONS FOR YOU ABOUT WHERE YOU LIVE WHEN YOU ARE NO LONGER CAPABLE OF MAKING THAT DECISION. IF YOU DO NOT PROVIDE SUCH AUTHORIZATION TO THE PERSON DESIGNATED IN THIS DOCUMENT, THAT PERSON MAY NOT BE ABLE TO ASSIST YOU TO MOVE TO A MORE SUPPORTIVE LIVING ARRANGEMENT WITHOUT OBTAINING APPROVAL THROUGH A JUDICIAL PROCESS.

(7) 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.

(8) 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.

(9) 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.

(10) THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

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

(12) YOU MAY REQUEST THAT THE NEVADA SECRETARY OF STATE ELECTRONICALLY STORE WITH THE NEVADA LOCKBOX A COPY OF THIS DOCUMENT TO ALLOW ACCESS BY AN AUTHORIZED PROVIDER OF HEALTH CARE AS DEFINED IN NRS 629.031.

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

I, _____, hereby designate and appoint:

Name: _____

Address: _____

_____

Telephone Number: _____

as my agent to make health care decisions for me as authorized in this document.

## 2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document and pursuant to §162A.700 and following of Title 13 of the Nevada Revised Statutes, 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: 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; subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

## 4. SPECIAL PROVISION 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 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 your 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 line below the statement.)

(a) 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.

_____
Initials

(b) If I am in a coma which my doctors or advanced practice registered nurses have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used.

_____
Initials

(c) 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.

_____
Initials

(d) 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.

_____
Initials

(e) 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, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

_____
Initials

(f) If I have an incurable or terminal condition, including late stage dementia, or illness and no reasonable hope of long-term recovery or survival, I desire my attending physician to administer any medication to alleviate suffering without regard that the medication is likely to cause addiction or reduce the extension of my life.

_____
Initials

(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.)

When necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice"; and;

(b) Any necessary waiver or release from liability required by a hospital or physician.

Other or Additional Statements of Desires:

_____

_____

_____

_____

## 7. STATEMENT OF DESIRES CONCERNING LIVING ARRANGEMENTS.

(If the statement reflects your desires, initial the line below the statement.)

A. I desire to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my activities of daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me.

_____
Initials

B. I desire to live in my home for as long as possible without regard for my medical needs, personal safety or ability to engage in activities of daily living. My agent may arrange for a natural person, an employee of an agency or a provider of community-based services to come into my home and provide care for me. I understand that, before I may be placed in a facility or home other than the home in which I currently reside, a guardian must be appointed for me.

_____
Initials

(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:

_____

_____

_____

_____

8. **DESIGNATION OF ALTERNATE AGENTS.**

*(You are not required to designate any alternative agent but you 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 not available or becomes ineligible to act, or if I revoke this appointment or authority to act, then I designate the following persons to serve as my alternate agents to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

First Alternate: Name: _____

Address: _____

_____

Telephone Number:_____

Second Alternate: Name: _____

Address: _____

_____

Telephone Number:_____

9. **PRIOR DESIGNATIONS REVOKED.**

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

10. **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 fact that he or she may be a beneficiary of my estate.

11. **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, then my agent is 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.

12. **NOMINATION OF GUARDIAN.**

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

13. **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 (HIPAA), 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 this _____ day of _____, 2020, _____ County, Nevada.

_____

**(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 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 _____ )

On this _____ day of _____, 2020, before me, _____, a Notary Public, personally appeared _____, 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.

WITNESS my hand and official seal

_____
NOTARY PUBLIC

# STATEMENT OF WITNESSES

(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 attorney-in-fact; (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 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 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 community care facility, nor an employee of an operator of a health care facility.

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

*(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 his/her death under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Address: _____

_____

Date: _____

Signature: _____

Print Name: _____

Address: _____

_____

Date: _____

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. This includes requesting the Nevada Secretary of State to electronically store this document with the Nevada Lockbox to allow access by authorized providers of healthcare.

# INSTRUCTIONS

## NEVADA STATUTORY DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

The Durable Power of Attorney for Health Care Decisions is an important legal document. It gives your Health Care Agent the power to make medical decisions, sign consents and/or releases with hospitals and/or doctors when you can't speak for yourself.

**Warnings:** Read the twelve (12) warnings at the beginning of the document.

**Paragraph 1:**

Print your full name.

Print the full name, address, and telephone number of the person you want to be your Health Care Agent.

If you wish to name Co-Health Care Agents or more than two (2) Alternate Health Care Agents, you will need to create your Health Care Directive using our software. There is no charge to create your Health Care Directive using our software. Click here to use our software for FREE to create your Health Care Directive.

**Paragraph 4:**

Print any types of treatment or placement that you do not want your Heath Care Agent to give consent for or other restrictions you wish to place on your Heath Care Agent's authority, such as prohibiting chemotherapy or blood transfusions. Do not add any restrictions unless you want those restrictions to be absolute in all circumstances. Most people prefer to leave it to the discretion of their Health Care Agent. If you want to leave it to the discretion of your Health Care Agent, print "None" in Paragraph 4.

If you need additional space to list restrictions, email me at JohnClarkson@everythinglivingtrusts.com and I will send you the Durable Power of Attorney as a Word document so you can add additional lines.

**Paragraph 5:**

Your Health Care Power of Attorney will exist indefinitely unless you specify a shorter time. Most people prefer for their Health Care Power of Attorney to last indefinitely, but if you want it to end on a certain date, print the date in Paragraph 5.

**Paragraph 6:**

You may, but are not required to, indicate your desires concerning withholding or withdrawing life-sustaining treatment. If your desires are unknown, your Health Care Agent has a duty to act in your best interests, and under some circumstances a judicial proceeding may be necessary to determine your best interests. Therefore, it is in your best interest to indicate your desires.

Initial one or more of the Statements of Desires in Paragraph 6. Please consider these Statements of Desires carefully.

Also, in Paragraph 6 you can add other or additional statements of desires, instructions, and clarifications, such as:

- Whether you never want to be placed in a long-term care facility and that your long-term care be provided in your own home or the home of a caregiver or in an assisted-living facility;

- Instructions regarding when specific life-support systems and treatments should be withdrawn or withheld;

- Whether you want an attempt to be made at resuscitation (CPR) or allowed to die a naturally;

- Whether you want to be put on a respirator;

- Whether you want to be administered antibiotics;

- Whether you want dialysis;
- Whether you want to donate viable organs for transplant;
- Whether you want to donate viable tissues for transplant; and
- Any other desires, instructions, and clarifications you would like to express.

You are not required to add any additional statements of desires, instructions, and clarifications. If you do not want to add any additional statements of desires, instructions, and clarifications, print "None" in Paragraph 6. If you would like to add statements of desires, instructions, and clarifications, print the statements of desires, instructions, and clarifications in Paragraph 6.

If you need additional space to list any additional statements of desires, instructions, and clarifications, email me at JohnClarkson@everythinglivingtrusts.com and I will send you the Durable Power of Attorney as a Word document so you can add additional lines.

**Paragraph 7:**

You may, but are not required to, indicate your desires concerning living arrangements.

Initial only one of the Statements of Desires in Paragraph 7. Please consider these Statements of Desires carefully.

Also, in Paragraph 7 you can add other or additional statements of desires. If you do not want to add any additional statements of desires, print "None" in Paragraph 7. If you would like to add statements of desires, print the statements of desires in Paragraph 7.

If you need additional space to list any additional statements of desires, email me at JohnClarkson@everythinglivingtrusts.com and I will send you the Durable Power of Attorney as a Word document so you can add additional lines.

**Paragraph 8:**

You may, but are not required to, name alternate Health Care Agent(s) to act for you if the Health Care Agent you named in Paragraph 1 is unable or unwilling to act as your Health Care Agent. If you name more than one alternate Health Care Agent, the alternate Health Care Agents will act in the order listed.

If you are naming an alternate Health Care Agent(s), print their name, address, and telephone number where indicated.

If you wish to name Co-Health Care Agents or more than two (2) Alternate Health Care Agents, you will need to create your Health Care Directive using our software. There is no charge to create your Health Care Directive using our software. Click here to use our software for FREE to create your Health Care Directive.

**Signing:**

You must sign your Durable Power of Attorney for Health Care Decisions in the presence of either a Notary Public or two witnesses.

**Notarized:**

If you are signing your Power of Attorney in the presence of a Notary Public, print the day, the month, and the name of the County as indicated, and ten sign your name. The Notary Public will then complete the Certificate of Acknowledge of Notary Public. You can have your Power of Attorney notarized at my office or in the safety of your home or office remotely. Click here for information and to schedule an appoint to have your Power of Attorney notarized.

**Witnesses:**

If you are signing your Power of Attorney in the presence of two qualified witnesses, please read carefully the witness procedure in the “Statement of Witness” on Page 8. If you do not comply with the witnessing procedure, you Power of Attorney will be invalid.

Each witness must declare under penalty of perjury to the statements in the Statement of Witnesses on Page 8. Each witness must then sign their name, print their name and address, and the date they signed the Statement of Witnesses.

Then one or both of the witnesses must declare under penalty of perjury to the statements in the Declaration on Page 9. The witness or witnesses must then sign their name, print their name, address, and the date they signed the Declaration.

**Nevada Secretary of State Lockbook:**

After you have completed and signed your Power of Attorney, you may store it electronically Free of charge with the Nevada Secretary of State Lockbox. Authorized healthcare providers may then access your Power of Attorney electronically when needed instead of you providing a paper copy of your Power of Attorney to them. The Nevada Secretary of State will also mail you a wallet card to show your healthcare provides verifying that you have a Power of Attorney. The wallet card is also useful to emergency medical personnel. Click here to submit your Power of Attorney to Nevada Lockbox.

**Conclusion:**

If at any time you have any questions, you can contact me by email at JohnClarkson@everythinglivingtrusts.com, by completing a contact form, by Chatting with us, or calling us at 775-324-1111.

Also, please visit our website at https://everythinglivingtrusts.com for information about do-it-yourself online attorney-quality comprehensive estate plans at unbeatable prices.