DURABLE POWER OF ATTORNEY FOR HEALTHCARE
ADVANCE HEALTHCARE DIRECTIVE
JOHN A. DOE

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.

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 AGENT OR THE TREATING PHYSICIAN, HOSPITAL OR OTHER PROVIDER OF HEALTH CARE.

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.

DURABLE POA HEALTHCARE -- ADVANCE HEALTHCARE DIRECTIVE

1. DESIGNATION OF HEALTH CARE AGENT.

I, **JOHN A. DOE** (DOB _____), do hereby designate and appoint:

Name: **JANE B. DOE**
Address: 1234 Main St, Carson City, NV 89703
Phone: 555-123-4567 email: JustJane@gxmail.com

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

2. NAMING AN ALTERNATE AGENT: I want the following persons in the order listed to make health care decisions for me if I cannot and my agent is not willing, able or reasonably available to make them for me:

	1st Alternative Agent:	2nd Alternative Agent:
Name:	**LUCY SMITH**	**AGNES BROWN**
Address:	12 Apple Ct, Reno, NV 89521	34 Pear Ave, Reno, NV 89521
Phone:	555-555-1234	555-555-5678
Email:	LucyLu@gxmail.com	AgnesB@gxmail.com

SURROGATE. If none of the above are available, then I authorize the following persons listed in NRS 139.040 to act as my agent in the priority listed. (e.g. 1-surviving spouse or domestic partner, 2-adult children, 3-adult grandchildren, 4-other adult issue, 5-parent, 6-adult sibling).

3. 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. By signing this document, I revoke any prior durable power of attorney for health care that I may have made. 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.

4. 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, 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.

INSTRUCTIONS TO CARE PROVIDERS

LIFE-SUSTAINING TREATMENT. This section gives you the opportunity to say how you want your agent to act while making decisions for you. You may initial each item or leave any item blank.

Prolonging life vs. dying a natural death

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. In other words keep my body alive even if my doctors have reasonably concluded that there is no reasonable hope for long term recovery or survival or that my coma (if I have one) is irreversible.

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.

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.

4. (___) I have reviewed the Nevada POLST form. If in the future, I have not executed a POLST form and my physician determines, or my agent suspects that, execution of a POLST is appropriate then my agent is authorized to execute a POLST on my behalf in accordance with my wishes stated in this my Durable Power of Attorney for Health Care.

GI feeding tube or IV. I understand that withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. For some people receiving nutrition after all other treatment is ended may still be a tenet of their religion. For some people it may not make sense to continue this when all other treatment is terminated.

5. (___) I do not want continued artificial nutrition and hydration (e.g. gastrointestinal feeding tube or intravenous liquids) after all other treatment is terminated.

6. (___) I do want continued artificial nutrition and hydration (e.g. gastrointestinal feeding tube or intravenous liquids) after all other treatment is terminated. If I initial this section, you are asked to continue to give me the artificial nutrition and hydration.

Experimental procedures, treatments and drugs. I understand that it can take a long time to obtain FDA approval for new medical procedures, treatments and drugs. As a result, many are categorized as “experimental”. I also understand that some of such procedures, treatments or drugs have a good record of success and that some contain risks. I also understand that experimental procedures, treatments and drugs can only be given to me if I authorize them.

7. (___) I authorize my agent to enroll me in experimental procedures or treatments if said procedures or treatments are recommended by my physician and my agent consents. 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 in making that decision. My agent is to consider whether the expected benefits outweigh the burdens of the treatment or drug.

8. (___) I do not want any experimental procedures, treatments or drugs.

Palliative care (Dying with dignity/Use of pain relieving drugs)

9. (___) When I die, I wish to do so with dignity, grace and without pain and suffering. If I have an incurable or terminal condition, including but not limited to, late stage dementia, and no reasonable hope of long-term recovery or survival, I desire my attending physician to administer any medication to alleviate suffering without regard to the fact that the medication may be addictive or may reduce the extension of my life.

10. (___) I do not wish to have any medication that may be addictive or reduce the extension of my life.

Assisted living.

11. (___) 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 or reasonable 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, and allow me to participate in the decision of said facility or home. If I am married, placement shall be done in a manner that considers my spouse's support needs.

12. (__) I refuse to be placed in any assisted living facility. 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, which means that a Court action would be needed to remove me from my home.

Cognitive rehabilitation or other mental healthcare

13. (___) I authorize my agent to admit me as a <u>voluntary</u> patient to a facility for mental health or place me in rehabilitative care if my agent determines such treatment is best for my health and safety, or if recommended by a physician.

14. (___) I do not authorize my agent to admit me as a voluntary patient to a facility for mental health or place me in rehabilitative care even if my agent determines such treatment is best for my health and safety, or even if recommended by a physician.

ACCESS TO MY HEALTH INFORMATION (HIPPA). I give my agent permission to examine and share information about my health needs and health care if I am not able to make decisions for myself. By signing this form I give the authorization and 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.

GUIDANCE FOR MY AGENT. The instructions I have stated in this document should guide my agent in making decisions for me (initial or mark one of the below items to tell your agent more about how to use these instructions):

15. (___) I give my agent permission to be <u>flexible</u> in applying these instructions if he or she thinks it would be in my best interest based on what they know about me and the recommendations of the attending physician.

16. (__) I want my agent to follow these instructions <u>exactly as written</u> if possible, even if he or she thinks something else is better.

GOOD FAITH CARE. My wish is that the provider of healthcare be working cooperatively with me and my Agent for my care. To that end, a provider of health care who relies in good faith on the provisions of this advance directive shall be immune from criminal and civil liability applicable to the withholding or withdrawal of life-sustaining treatment. As such, the liability protection provisions already in law in NRS 449A.727 shall apply whether or not this advance directive is retrieved from the Registry established by the Nevada Secretary of State.

NOMINATION OF GUARDIAN. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions. Filling this out does NOT mean you want or need a guardian right now. If a court appoints a guardian to make personal decisions for me, I want the court to choose my agent named in this form. If my agent cannot be a guardian, I want my alternate agent(s) in the order named in this form. If I prefer someone other that the agent(s) named in this form, their name and their contact information is:_____
_____

ORGAN DONATION

17. (__) I want to donate my organs, tissues and other body parts, except for those listed below (list any body parts you do not want to donate or any restrictions on use of the organs): .....

18. (__) I do not want my organs, tissues or body parts donated to anybody for any reason.

You may also designate organ donation on your driver license. If there is a conflict between this form and your driver license, the most recent shall control.

CHALLENGES

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by any person or healthcare provider, 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/Advanced Healthcare Directive must be construed and interpreted in accordance with the laws of the State of Nevada.

SIGNATURE WITH NOTARY OR WITH WITNESSES Either process is permitted under NRS 162A.790. You only need to use one of these methods.

Sign your name: _____ Today's date: January __, 2025

JOHN A. DOE

STATE OF NEVADA)
)ss:
CARSON CITY)

On this ___ day of January, 2025, before me, the undersigned, a Notary Public, personally appeared JOHN A. DOE, 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 executed it.

(SEAL) _____
NOTARY PUBLIC

COPIES: You should retain an executed copy of this document and give one to your agent, your primary medical care provider or any other provider of your healthcare.

INFORMATION FOR AGENTS

(1) If this form names you as an agent, you can make decisions about health care for the person who named you when they cannot make their own.
(2) If you make a decision for the person, follow any instructions the person gave, including any in this form.
(3) If you make a decision for the person and you don't know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences and goals if you know them or can learn them. Some of those preferences might be in this form. You should also consider any behaviors or communications from the person that indicate what they currently want.
(4) If this form names you as an agent, you can also get and share the person's health information. But you can only obtain or share this information to assist in their health care.