DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Including Advanced Directive to Physicians and Designation of Personal Representative under HIPAA)

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 ATTORNEY-IN-FACT ("HEALTH-CARE 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 INCLUDES 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. 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, SO LONG AS YOU HAVE SUFFICIENT MENTAL CAPACITY TO GIVE INFORMED CONSENT, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY BE STOPPED IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THE 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 AND PERSONAL REPRESENTATIVE.** I, the "Principal" named below, do hereby designate and appoint the "Health-care Agent" named below as my attorney-in-fact and as the guardian of my person to make health care decisions for me as authorized in this document. "Agent," "health-care agent," and "attorney-in-fact" are used interchangeably in this document to refer to the health-care agent and any alternate serving under this instrument. I hereby designate the health-care agent (including each alternate designated herein) as my "personal representative" for purposes of HIPAA (as defined in subparagraph 13.f).

PRINCIPAL	
HEALTH-CARE AGENT	*(Include name, address & telephone.)*
FIRST ALTERNATE HEALTH-CARE AGENT	*(Include name, address & telephone.)*
SECOND ALTERNATE HEALTH-CARE AGENT	*(Include name, address & telephone.)*
THIRD ALTERNATE HEALTH-CARE AGENT	*(Include name, address & telephone.)*

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document, I hereby create a durable power of attorney by appointing the person designated above (including each alternate named herein) as my health-care agent to make health care decisions for me. This document is effective immediately and shall not be affected by my subsequent incompetence, disability, or other incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. I hereby grant to the health-care 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, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or paragraph 7. If I have not indicated with my initials that I agree or disagree with an option that is stated in this form, my intent is to leave the decision to my health-care agent, whose decision shall be final. I specifically authorize my health-care agent to:

a. Confer with health-care providers and professionals regarding my health and care.

b. Confer with and exchange personal information with any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse.

c. Authorize or decline to authorize surgery and/or the administration of medications (subject to the provisions of paragraphs 4 and 7).

d. Authorize or refuse to authorize my admission to a hospital, convalescent center, nursing home, hospice, or other health-care institution (other than commitment to a mental health treatment facility and subject to the provisions of paragraphs 4, 6, and 7).

e. Arrange for my long-term care (subject to the provisions of paragraph 6).

f. Review and receive copies of personal information (as defined in subparagraph 13.i) and to release or authorize the release of such information to others, as my health-care agent shall deem appropriate. I acknowledge that information disclosed by a healthcare provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by law (including 45 CFR § 164).

g. Authorize one or more physicians or psychologists to examine me for the purpose of determining whether or not I am incompetent, am disabled, am incapacitated, have the legal and/or mental capacity to make a will, trust, other legal document, or modification thereof, have the legal and/or mental capacity to serve as a fiduciary, and to release the findings of such examination to such persons or entities as my agent shall deem appropriate.

h. Sign documents on my behalf to carry out the powers granted herein, including waivers or releases of liability required by any health care provider or any custodian of records.

i. Visit me in a medical facility, facility for the dependent or home for individual residential care. I hereby instruct all staff of a medical facility, facility for the dependent or home for individual residential care in which I am a patient to admit my health-care agent to my room and afford said agent the same visitation rights as are provided to members of my family who are legally related to me during my time as a patient.

j. Each person designated as an alternate health-care agent herein (including each individual named as a co-agent) shall have the same powers as the acting health-care agent except as to the making of decisions hereunder, including the right to receive personal information, to confer with medical care providers, and to be permitted visitation rights.

4. SPECIAL PROVISIONS AND LIMITATIONS. In exercising the authority under this durable power of attorney for health care, the authority of my health-care agent is also subject to the following special provisions and limitations: *(Initial here if there are no other limitations: _____) (Initial here if the following limitations apply: _____)*

5. DURATION. This power of attorney will exist indefinitely from the date I execute this document until revoked by me in writing.

6. STATEMENT OF DESIRES AS TO LONG-TERM CARE AND CAREGIVERS. With respect to my long-term care, my health-care agent is authorized to act in my best interest, as my health-care agent may determine. I specifically authorize my health-care agent to make decisions relating to my long-term care, subject to the statements in this paragraph 6 that I have initialed. ***If I have not initialed a particular statement, any decisions related to that statement shall be made in my agent's discretion.*** If, after consulting with my physician, other health-care providers, and my family, my health-care agent determines that I need long-term care, my health-care agent shall have the full and unrestricted discretion to select my: physician and other health-care providers; health-care facilities; caregivers; and/or long-term care facility.

a. It is my wish that I never be placed in a long-term care facility and that my long-term care be provided either in my own home or in the home of my caregiver.

As to 6.a*: I agree:*_____. *I disagree*_____. *As my Agent decides*_____.

b. For the purposes of subparagraph 6.a, "my home" may include an assisted-living facility.

As to 6.b*: I agree:*_____. *I disagree*_____. *As my Agent decides*_____.

c. _____. *(Initial here if the following statement of other desires applies):*

7. STATEMENT OF DESIRES AS TO LIFE-SUSTAINING PROCEDURES. With respect to decisions relating to the withholding and/or withdrawal of life-sustaining procedures, my health-care agent is authorized to act in my best interest, as my health-care agent may determine. I specifically authorize my health-care agent to make decisions relating to the withholding and/or withdrawal of life-sustaining procedures, subject to the remaining provisions of this paragraph 7. I have indicated my desires by initialing below that I agree or disagree with the following statements, which shall constitute a directive to my family and loved ones, to each health-care agent appointed hereunder, to my physicians, and to health care providers and all others who may be responsible to provide medical care or make decisions related thereto. If I have not indicated that I agree or disagree with a particular statement, any related decision shall be left to my health-care agent's discretion. It is my intention that this directive be honored by my family, by my attending physician(s), and by all other persons as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of my refusal. As provided in NRS 449.613(2), it is also my intention that this declaration serve as a declaration under the Uniform Act on Rights of the Terminally Ill under the provisions of NRS 449.535 to 449.690, inclusive, as most recently amended.

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.

*As to 7.a: I agree:*_____. *I disagree*_____. *As my Agent decides*_____.

b. If I have an incurable or terminal condition or illness and there is no reasonable hope of my long term recovery or survival, I desire life-sustaining or prolonging treatments be withheld or withdrawn, and that I be permitted to die naturally.

*As to 7.b: I agree:*_____. *I disagree*_____. *As my Agent decides*_____.

c. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments be withheld or withdrawn, and that I be permitted to die naturally. I do not want life-sustaining procedures used if there is no reasonable hope that I will regain my ability to understand and respond to my circumstances.

*As to 7.c: I agree:*_____. *I disagree*_____. *As my Agent decides*_____.

d. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My health-care agent and health-care providers are 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.

As to 7.d: I agree:_____. I disagree_____. As my Agent decides_____.

e. I want efforts to be made to relieve my pain, even if life-sustaining procedures are withheld or withdrawn. My health-care agent is authorized to consent to pain-relief medications and treatments, even if there are adverse side effects and even if there is a potential for habituation, addiction, or dependence.

As to 7.e: I agree:_____. I disagree_____. As my Agent decides_____.

f. When life sustaining or prolonging treatments are to be withdrawn and/or withheld, then as to artificially administered nutrition and hydration: *(You may only agree with one of the following.)*

i. Artificially administered nutrition and hydration may never be withdrawn or withheld.

As to 7.f.i: I agree:_____. I disagree_____. As my Agent decides_____.

ii. Artificially administered nutrition and hydration may be withdrawn or withheld unless the withdrawal or withholding would result in death from dehydration or starvation rather than from my existing disease, illness or injury.

As to 7.f.ii: I agree:_____. I disagree_____. As my Agent decides_____.

iii. Artificially administered nutrition and hydration may be withdrawn or withheld even if the withdrawal or withholding would result in death solely from dehydration or starvation rather than from my existing disease, illness or injury.

As to 7.f.iii: I agree:_____. I disagree_____. As my Agent decides_____.

g. *(Initial here if the following statements of other desires applies _____):*

8. POWER TO NEGATE DIRECTIVE. Notwithstanding anything to the contrary herein, I reserve the right to make any medical or health-care decision for myself so long as I have sufficient mental capacity to give informed consent with respect to the particular decision, and I reserve the right to object to a treatment and to object to the withholding or stopping of a treatment.

9. DESIGNATION OF ALTERNATE HEALTH-CARE AGENT. If the person designated above as my health-care agent is unavailable, cannot be contacted, or is otherwise unwilling or unable to make

health care decisions for me, then the alternate health-care agents shown in paragraph 1, above, shall act to make health care decisions for me as authorized in this document. The alternate health-care agents shall be contacted in the order named; provided, that the first available health-care agent may serve without further documentation. If no named health-care agent (including an alternate) is available, able, and willing to serve, the desires expressed herein — including the applicable provisions of paragraphs 4, 7, and 11 — shall nevertheless remain in effect.

10. AGENTS ACTING JOINTLY. If I have designated agents to act jointly, the decisions made hereunder shall be made by majority vote of the agents; provided, however:

a. Any agent may act alone if the other agent(s) cannot be contacted or refuse to act or an urgent decision must be made or it is otherwise impractical to contact the other agent(s).

b. Any decision to withhold or withdraw life-sustaining treatments or procedures in accordance with the provisions of section 7 shall be made by the unanimous decision of my health-care agents.

11. UNIFORM ANATOMICAL GIFT ACT. Pursuant to NRS 451.500 et seq., I hereby make a gift of my physical remains pursuant to the Nevada Uniform Anatomical Gift Act:

a. *(Initial here if the following applies: _____)* I direct that no gift be made of my physical remains or any part thereof. *(If you initial this subparagraph, no gift of your physical remains shall be made, and you should skip the balance of this paragraph 11.)*

b. No gift of my physical remains shall be made for any purpose listed below if I have initialed under the "No" column next to that purpose. I make a gift of my physical remains for the purposes next to which I have initialed in the "Yes" column and, with the consent of my health-care agent, for the purposes next to which I have initialed in the column labeled "As my agent decides".

Purpose	Yes	No	As my agent decides
The treatment of or therapy for illness or disease of a living human.			
Transplanting into a living human being.			
Medical research			
Scientific research			

c. Subject to the approval of my health-care agent (unless no health-care agent is able and willing to act):

i. The portion of my remains donated shall include all body parts, humors, and tissues that can be used for the purposes indicated.

ii. This anatomical gift is made to any physician, dentist, hospital, university, clinic, or organization that can use the donated organs for the specified purposes.

d. This anatomical gift is made on the condition that all expenses associated with this gift shall be borne by the donee.

12. DISPOSITION OF MORTAL REMAINS; MEMORIAL SERVICE. In compliance with NRS 451.024(5), I hereby grant to my health-care agent the power to direct the disposition of my mortal remains after my death, subject to the provisions of paragraph 11 herein and the following:

a. I direct that my mortal remains be buried.

As to 12.a: I agree:_____. I disagree_____. As my Agent decides_____.

b. I direct that my mortal remains be cremated.

As to 12.b: I agree:_____. I disagree_____. As my Agent decides_____.

c. Initial one of these choices:

i. _____ I do not want a funeral or other memorial service.

ii. _____ After conferring with my family, my health-care agent is directed to make such arrangements for a funeral or other memorial service as my health-care agent deems appropriate.

iii. _____ My health-care agent is directed to make the arrangements for a funeral or other memorial services in accordance with the instructions that are attached hereto.

d. *(Initial here if the following statements of other desires applies _____):*

13. DEFINITIONS.

a. "Artificially administered nutrition and hydration" includes parenteral feeding, intravenous feedings, and endotracheal or nasogastric tube use.

b. A "beneficiary" of mine is anyone who will receive any property or other economic benefit by reason of my death, including, but not limited to: a beneficiary under a will or trust; a joint tenant or other person holding property jointly with me in a form that includes a right of survivorship; and/or a beneficiary under a contract, such as a life insurance contract, an individual retirement account or other transfer-on-death arrangement.

c. "Caregiver" refers to the individual who is responsible for my daily physical care when I am in need of long-term care that is not being provided in an institution such as a hospital, hospice, nursing home, or convalescent center.

d. "Coma" shall include any comatose condition, persistent vegetative state, or permanent unconsciousness.

e. "Health-care provider" includes any person or entity that provides any services related to my health care, including any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, or pharmacy. The term also includes any person or entity that is considered a health-care provider under HIPAA.

f. "HIPAA" refers to the federal Health Insurance Portability and Accountability Act of 1996 and related regulations (42 USC § 1320d and 45 CFR §§ 160-164).

g. "Life-sustaining procedure" refers to any treatment or procedure which utilizes mechanical or intervention that, when administered to a patient, serves only to prolong the process of dying. It includes, but is not limited to, chemotherapy, radiation treatments, cardiopulmonary resuscitation, surgery, dialysis, use of a respirator, blood transfusions, antibiotics, pacemakers, insulin pumps, and transplants.

h. "Long-term care" refers to physical care that I am unable to provide for myself that is anticipated to be required for at least 90 days or, if shorter, the balance of my anticipated life expectancy. Long-term care excludes hospitalization and hospice care, but it refers to care and treatment in a nursing home, convalescent center, assisted-living facility, or in my home under the direction of a caregiver.

i. "Personal information" includes, without restriction, any information governed by HIPAA, including private, privileged, protected, or personal health information. "Personal information" specifically includes:

i. All records relating to: my medical history, health-care insurance, and other financial information related to the payment for my health and medical care; life insurance; and other financial information related to the payment for the disposition of my mortal remains and any memorial service.

ii. All of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

14. WAIVER OF CONFLICT OF INTEREST. If any designated health-care agent designated herein is a beneficiary of any property interest that might pass to his or her after my death, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that beneficiary may have by reason of the fact that he or she may be a beneficiary of mine.

15. 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, but I request that it be honored wherever I may require medical treatment.

16. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

(BEFORE THIS POWER IS VALID, YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY, AND IT MUST BE WITNESSED BY TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE.)

I sign my name to this Durable Power of Attorney for Health Care on _____ *(date)* at Las Vegas, Nevada. I understand the full import of this document and I am emotionally and mentally competent to execute it. This document constitutes an affidavit of the declarations made herein, and, in compliance with NRS 53.045 (which permits unsworn declarations to serve as an affidavit without a notary), I declare under penalty of perjury that the foregoing is true and correct.

_____

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. You must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your health-care 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 personally known to me, that the principal signed or acknowledged this durable power of attorney for health care 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 health-care 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, nor an employee of an operator of a health care facility.

_____	_____
↑Sign on the line above↑	↑Sign on the line above↑
_____	_____
↑Print name on the line above↑	↑Print name on the line above↑
_____	_____
↑Date↑	↑Date↑
Print residence address below:	Print residence address below:
_____	_____
_____	_____

(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.

↑Sign on the line above↑	↑Sign on the line above↑
↑Print name on the line above↑	↑Print name on the line above↑
↑Date↑	↑Date↑
Print residence address below:	Print residence address below:

***Copies**: You should retain an executed copy of this document and give one to your health-care agent. A copy should be given to your primary physician for his or her file, and you should also consider giving copies to other health care providers who are currently treating you.*

YOUR DURABLE POWER OF ATTORNEY FOR HEALTH CARE

by Layne T. Rushforth

1. OVERVIEW: By signing a "Durable Power of Attorney for Health Care" (referred to in this memo as a "DPAHC"), you are authorizing one or more persons to make health-care decisions for you if you cannot make them for yourself. The person you name is referred to as your "health-care agent" or "health-care attorney-in-fact". Unless you specify otherwise, your health-care agent can use this form to obtain information regarding your health and health treatment, visit you in medical facilities, and authorize all types of health and medical care, including surgery, medication, nursing home care, etc. This memo is intended to help you decide which options to initial and to help you decide what, if any, personalized provisions you want to add. The DPAHC is effective immediately so that your health-care agent has authority as a "personal representative" as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996 (referred to herein as "HIPAA").

2. CUSTOMIZING THE FORM: The "Durable Power of Attorney for Health Care" (or "DPAHC") form is substantially in the form prescribed by Nevada law, although we have attempted to clarify some of the options in the form itself. It becomes <u>your</u> document when it is properly completed, you have initialed the desired options and added any desired clarifications and instructions of your own, and you have signed the document and acknowledged it before two witnesses or a notary public.[1]

a. **Your Agent and Alternates**. You should name someone to act in your behalf, and, if possible, you should also name one or more alternates who can act if your first choice is unavailable or unwilling to act. The document should include an address and phone number (and perhaps a telecopier/fax number) for each agent designated to expedite communication in an emergency. Doctors and other health-care providers should <u>not</u> be designated as health care agents unless they are family members or unless they will not be rendering any treatment pursuant to the power.

b. **Customized Form**. The statutory DPAHC form has two places where customized instructions can be given. The comments in this memo attempt to explain your option(s), but they are not intended to recommend any particular option.

i. <u>Restrictions</u>. Nevada law does not permit this form to be used for "commitment to or placement in a mental health treatment facility, convulsive treatment, psycho-surgery, sterilization, or abortion." You may add other restrictions of your own, such as prohibiting chemotherapy or blood transfusions.

(1) *Prohibitions.* If you wish to add such restrictions, they need to be inserted at the end of paragraph 4, but do not put any restrictions unless you want those restrictions to be absolute in all circumstances.

(2) *Discretion.* Most clients prefer to leave it to the discretion of the health-care agent under the circumstances, and if you feel that way, you should

[1]Under Nevada law, a durable power of attorney for health care must be witnessed by two qualified witnesses or it should be notarized. Because the notary option may not be valid for the living will provisions or the anatomical gift provisions that are included in our form, two witnesses are required and there is no notary option.

initial the blank at the end of paragraph 4. If you want to express your desires, you may give them as guidelines (e.g., "I prefer not to receive chemotherapy if I cannot make the decision myself. . . .") or as absolute prohibitions ("I never want chemotherapy under any circumstances or conditions. . . .").

ii. Long-Term Care. In paragraph 6, you are given the option of expressing your desires with respect to your long-term care. In this document, "long-term care" is defined as physical care you are unable to provide for yourself for at least 90 days (or for the balance of your life, if shorter). You may give the health-care agent the power to select your physician and other health-care providers, health-care facilities, caregivers, and/or long-term care facility. If you prefer home care over care in a long-term care facility, you should initial that statement, and you can also indicate that your "home" includes an assisted-living facility. The last subparagraph of paragraph 6 can be completed and initialed if you want to add personalized instructions related to your long-term care.

iii. Artificial Life Support Choices. There are several options you must consider with respect to the administration of life-sustaining treatments. These are set forth in paragraph 7 of the Durable Power of Attorney for Health Care. If you agree that a subparagraph expresses your wishes, initial the first blank under the paragraph. If you disagree with the statement, initial that you disagree in the second blank. If you do not wish to express any desires, you should initial the third option ("*As my Agent decides*"), leaving the decision up to your health-care agent.

(1) *Maintain Life Support.* If you indicate that you agree with subparagraph 7.a., you are stating that you want to be kept alive as long as possible, regardless of your chances for recovery, regardless of the slim chance for survival, and regardless of the cost. If you agree with this subparagraph, you may not agree with 7.b, 7.c, or 7.d because they are inconsistent with 7.a. (Comment: Most people do not want to be kept alive on artificial life support systems "to the greatest extent possible", so they disagree with subparagraph 7.a.)

(2) *Unrecoverable Illness or Injury*. If you do not want life-sustaining procedures used when there is no reasonable hope that you will recover from your illness or injury, initial that you agree with subparagraph 7.b.

(3) *Coma.* If you do not want life-sustaining procedures used if you are in an irreversible coma (or coma-like condition), initial that you agree with subparagraph 7.c.

Comment on 7.b. and 7.c.: *Subparagraph 7.b. relates to unrecoverable illness or injury and 7.c. relates to irreversible comas. It is uncommon to initial one without the other, but there is a difference. As to each option you agree with, you are expressing a desire to die naturally. As to each option you disagree with, you are expressing a desire for life-sustaining treatments and procedures. As to either option that you do not initial at all, your health-care agent may make the determination.*

(4) *Quality of Life.* Subparagraph 7.d. expresses a desire not to have life-sustaining procedures used if the benefits of treatment are unlikely to outweigh the burdens. "Quality of life" is a factor to be considered, in addition to any possible extension of your life expectancy. (Comment: When considering a treatment or procedure, this option gives your health-care agent authority to balance quality and quantity of life. In other words, if a painful and expensive procedure will possibly give you another 3-6 months, but only in a vegetative state, your health care agent may determine that life-sustaining procedures are not in your best interest.)

(5) *Pain.* Subparagraph 7.e. expresses a desire for pain relief, even if life-sustaining treatments or procedures are withheld or withdrawn.

(6) *Authority to Withdraw Artificially Administered Nutrition and Hydration.* Subparagraph 7.f. relates to the withdrawal or withholding of artificially administered nutrition and hydration.

(a) Option 7.f.i requires that artificially administered nutrition and hydration never be withheld or withdrawn. In other words, feeding and nutrition tubes or devices cannot be withdrawn or withheld even if other life-sustaining procedures are withdrawn or withheld.

(b) Option 7.f.ii permits, but does not require, your health-care agent to withhold and/or remove artificially administered nutrition and hydration at the same time life-sustaining procedures are withheld and/or withdrawn; however, it may not be withheld or withdrawn if you would die of starvation or dehydration rather from your existing illness or injury.

(c) Option 7.f.iii allows nutrition and hydration to be withheld or withdrawn even if you may die of starvation or dehydration rather than from your existing illness or injury.

Comment on 7.f. *You should agree with only one provision under this subparagraph, and you should disagree with the others.*

If you never want artificially administered nutrition and hydration withheld or withdrawn, you must initial that you agree with 7.f.i and that you disagree with 7.f.ii and 7.f.iii.

Initial that you agree with 7.f.ii. and that you disagree with 7.f.i and 7.f.iii if you want to allow the withholding or withdrawal of life-support systems except in cases where it is decided that you would die from starvation and/or dehydration rather than from your illness or injury.

If you want to give your health-care agent the greatest flexibility to permit or withhold nutrition and hydration, even if you may die from starvation and/or dehydration, rather from your illness or injury, initial that you agree with 7.f.iii, and initial that you disagree with 7.f.i and 7.f.ii.

(7) *Clarifications; Instructions.* Nevada law specifically allows you to insert your own instructions and clarifications regarding your health care and life-prolonging treatments. Initial 7.g. only if such additional instructions or clarifications are given in the space provided. As an example, some people want life-sustaining treatments withdrawn only after they have been in place for at least 72 hours. Others give more elaborate instructions regarding when specific life-support systems and treatments should be withdrawn or withheld.

iv. Anatomical Gift. You have the option to make a gift of your body parts, fluids ("humors"), or tissues.

(1) *No Gift.* If you initial subparagraph a of the paragraph titled Uniform Anatomical Gift, you are declining to make an anatomical gift.

(2) *Specified Purposes.* If you want to be an organ donor, you need to initial in the "Yes" column next to the purpose for which you agree to make the donation. Initial under the "No" column for each purpose that is not an acceptable purpose for you.

v. Funeral and Burial. You may direct your agent to bury or cremate your mortal remains (or both). You may also give instructions relating to a funeral or other memorial service. If you leave this section blank, it will be up to the family to decide what to do with respect to your mortal remains and any memorial service.

3. EXECUTION: You must sign the form in the presence of two "qualified witnesses", and the form explains who may not be a witness.[2]

4. REGISTRATION: The Nevada Secretary of State provides a living will "lockbox" service. For more information, point your web browser to http://www.nvsos.gov/index.aspx?page=214.

[Version of February 7, 2015]

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[2]Under Nevada law, a durable power of attorney for health care must be witnessed by two qualified witnesses or it should be notarized. Because the notary option may not be valid for the living will provisions or the anatomical gift provisions that are included in our form, two witnesses are required and there is no notary option.