DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 19XX;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108

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~ Lifecare Directives ~

Statutory Advance Directive

For Nebraska Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For Nebraska Residents

Statutory Compliant Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Nebraska Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Nebraska legislature has provided statutes guiding the construction of both a Living Will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will only be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

LIVING WILL DECLARATION

and Personal Instructions

(Pursuant to NRS Chapter 20, Article 4: §20–401 to §20-416)

1. INTRODUCTION: *The State of Nebraska Living Will was designed to assist those wishing to refuse life-sustaining treatment in terminal or permanently unconscious conditions (§20-403(9)). A* ***terminal condition*** *is defined as, "an incurable and irreversible condition that, without the administration of life-sustaining treatment, will...result in death with a relatively short time"(§20-403(11)). A* ***permanently unconscious*** *condition is referred to as a "persistent vegetative state" and is defined as "a medical condition that...is characterized by a total and irreversible loss of consciousness and capacity for cognitive interaction with the environment and no reasonable hope of improvement"(§20-403(6)).* ***Life-sustaining treatment*** *is defined as, "any medical procedure or intervention that...will serve only to prolong the process of dying or maintain the...patient in a vegetative state"(§20-403(5))*.

RIGHTS OF THE TERMINALLY ILL DECLARATION

(*Nebraska Living Will*)

2. I hereby declare that if I should lapse into a persistent vegetative state or 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 direct my attending physician, pursuant to the *Rights of the Terminally Ill Act*, to withhold or withdraw life sustaining treatment that is not necessary for my comfort or to alleviate pain.

SIGNATURE

3. Signed this_____day of _____, 20_____

Signed: _____

Address: _____

STATEMENT OF WITNESSES

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

5. Witness: _____

Printed Name:_____

Address: _____

6. Witness: _____

Printed Name:_____

Address: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

7. State of Nebraska,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the

instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**
Signature of Notary Public

_____
Date Commission Expires

SECTION II:
DESIGNATION OF HEALTH CARE AGENT
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
(Pursuant to NRS Chapter 30, Article 34, §30-3401 to §30-3432)

8. INTRODUCTION: *This section lets you name a person (called an "agent" or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further advice.*

9. ***Be it known that I***:
Full Legal Name: _____
Date of Birth: _____
Street Address: _____
City: _____ County: _____
State: _____ Zip Code: _____

~~ do hereby appoint:

10. **Name of Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

~~ as my attorney in fact for health care.

~~ I further appoint:

11. **Name of Alternate:** _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

~~ as my successor attorney in fact for health care.

12. I authorize my attorney in fact 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 have read the warnings stated in this document and understand the consequences of executing a power of attorney for health care.

13. I direct that my attorney in fact comply with the following instructions or limitations (*optional*): _____
_____
_____
_____
_____
_____
_____
_____

14. I direct that my attorney in fact comply with the following instructions on life-sustaining treatment: (*optional*): _____
_____
_____
_____
_____
_____
_____
_____

15. I direct that my attorney in fact comply with the following instructions on artificially administered nutrition and hydration: (*optional*): _____
_____
_____
_____
_____
_____
_____
_____

AFFIRMATION OF POWER OF ATTORNEY
PURPOSE AND INTENT

16. 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, 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.

17. Statement of my desire regarding a second physician's confirmation of my incapacity: (*initial only <u>one</u>*)

_____ I *<u>do</u>* require a second confirmation of incapacity;

OR,

_____ I do *<u>not</u>* require a second confirmation of incapacity;

~~ If requested, above, a second physician's confirmation of my incapacity shall be recorded in my medical record before any representative health care decisions are made by my appointed agent(s).

DECLARATION OF WITNESSES

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

19. Witness: _____

Printed Name:_____

Address: _____

20. Witness: _____

Printed Name:_____

Address: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

21. State of Nebraska,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**

Signature of Notary Public

_____

Date Commission Expires