POWER OF ATTORNEY FOR HEALTHCARE

I appoint _____, whose address & phone number is _____, as my attorney-in-fact for health care. As my successor attorney-in-fact for health care, I appoint _____, whose address & telephone number _____, as my successor attorney-in-fact for healthcare. 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 healthcare.

I direct that my attorney-in-fact comply with the following instructions or limitations:
I direct my attorney-in-fact to authorize the withholding or withdrawal of any medical procedure, treatment, or intervention that uses mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function which would, when applied to me, serve only to prolong my dying process or persistent vegetative state. If I should lapse into a persistent vegetative state or have an incurable and irreversible condition that, without the administration of life-sustaining treatment which could include but is not limited to artificially administered nutrition and hydration, will, in the opinion of my attending physician, serve only to prolong my dying process or persistent vegetative state, I direct my attorney-in-fact to authorize the withholding or withdrawal of life-sustaining treatment.

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 a 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.

Declarant Signature

Signed this _____day of _____, 20 _____

_____	_____
Signature	Printed Name
_____	_____
Social Security Number	Printed Address

Declaration of Witnesses

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:

_____	_____
Signature of Witness/Date	Printed Name of Witness
_____	_____
Signature of Witness/Date	Printed Name of Witness

-OR-

Notary *(You may sign this document before a notary public instead of having it witnessed above)*

STATE OF NEBRASKA)
) ss
COUNTY OF _____),
On this _____ day of _____ , 20____, before me, a notary public in and for _____, County, personally came _____personally known to be the identical person whose name is affixed to the above Living Will Declaration as declarant, and I declare that s(he) appears in sound mind and not under duress or undue influence, that s(he) acknowledges the execution of the same to be his/her voluntary act and deed.

Witness my hand and notarial seal at _____, Nebraska in such county, day and year last above written.

_____

Notary Public

↑ Affix Official Notary Seal Here ↑