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Legal Forms & Services

FirstName LastName

NEVADA HEALTH CARE DIRECTIVE & LIVING WILL

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive & Living Will in Nevada

After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Option 2: Notary Only

1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives and living wills, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive and living will. Review your state's laws on witness requirements for health care directives and living wills.

HEALTH CARE DIRECTIVE & LIVING WILL

FOR

FirstName LastName

This document includes the following:

Power of attorney for health care designating a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

Statement of desires concerning treatment with health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF HEALTH CARE AGENT.

I, FirstName LastName, do hereby designate and appoint:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Nevada 12345

Phone: 555-555-5555

Email: name@email.com

as my agent to make health care decisions for me if I am unable to make health care decisions myself as authorized in this document.

DESIGNATION OF ALTERNATE AGENT.

If the person designated above as my agent is unable to make health care decisions for me, then I designate the following person(s) to serve as my agent to make health care decisions for me as authorized in this document, such person(s) to serve in the order listed below:

First Alternate Agent

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Nevada 12345

Phone: 555-555-5555

Email: name@email.com

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 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; and subject only to the limitations and special provisions, if any, set forth below.

SPECIAL PROVISIONS AND LIMITATIONS.

In exercising the authority under this power of attorney for health care, the authority of my agent is subject to the following special provisions and limitations:

I do not wish to subject my agent to any special provisions or limitations at this time.

STATEMENT OF DESIRES CONCERNING TREATMENT.

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.

_____☑ 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.

☐ 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.

☐ 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.

_____☑ I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld.

_____☑ I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits.

_____☑ 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.

Other or additional statements of desire:

I do not wish to leave other or additional statements at this time.

PRIOR DESIGNATIONS REVOKED.

I revoke any prior power of attorney for health care.

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 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.

CHALLENGES.

If the legality of any provision of this power of attorney for health care is questioned by my physician, my advanced practice registered nurse, 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 power of attorney for health care must be construed and interpreted in accordance with the laws of the State of Nevada.

NOMINATION OF GUARDIAN.

If, after execution of this power of attorney for health care, proceedings seeking an adjudication of incapacity are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

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 and applicable regulations.

YOU MUST SIGN AND DATE THIS POWER OF ATTORNEY

This document will not be valid for making health care decisions unless it is either signed by at least two qualified witnesses (Option 1) who are personally known to you and who are present when you sign or acknowledge your signature or acknowledged before a notary public (Option 2).

I, FirstName LastName, sign this document voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: _____

Date signed: _____

If I cannot sign my name, I ask the person named below to sign for me.

Signature: _____

Printed Name:_____

TWO WITNESSES (OPTION 1)

Witness One. In my presence on _____ (date) FirstName LastName, who is known to me, acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not the principal's health care provider or an employee of principal's health care provider.
- I am not the operator of a health care facility involved with the treatment of the principal or an employee of a health care facility involved with the treatment of the principal.
- I am not named as a health care agent or an alternate health care agent in this document.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two. In my presence on _____ (date) FirstName LastName, who is known to me, acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not the principal's health care provider or an employee of principal's health care provider.
- I am not the operator of a health care facility involved with the treatment of the principal or an employee of a health care facility involved with the treatment of the principal.
- I am not named as a health care agent or an alternate health care agent in this document.
- I am not related to the principal by blood, marriage, or adoption.
- To the best of my knowledge, I am not entitled to any part of the principal's estate upon the death of the principal.

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

_____

Witness Two Phone: _____

OR

NOTARY PUBLIC (OPTION 2)

State of Nevada

County of _____

In my presence on _____ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Notary Public Signature: _____

Commission Expiration Date: _____