Legal Forms & Services

FirstName LastName

NEBRASKA
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 Nebraska
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 an attorney in fact 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 attorney in fact should act in my best interest.

PART I: POWER OF ATTORNEY FOR HEALTH CARE

I, FirstName LastName, appoint the following individual as my attorney in fact to make health care decisions for me:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Nebraska 12345

Phone: 555-555-5555

Email: name@email.com

If my first choice above is not willing, able, or reasonably available, I name the following individual as my successor attorney in fact to make health care decisions for me:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Nebraska 12345

Phone: 555-555-5555

Email: name@email.com

AUTHORITY OF ATTORNEY IN FACT 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. My attorney in fact must follow my health care instructions in this document or any other instructions I have given to my attorney in fact. If I have not given health care instructions, then my attorney in fact must act in my best interest, with due regard for my religious and moral beliefs, if known. Generally, my attorney in fact's authority includes the following:

- The same rights that I would have to request, receive, examine, copy, and consent to the disclosure of medical or other health care information.
- Consent or refuse to consent to care, treatment, service, or procedures
- Select or discharge health care providers
- Approve or disapprove proposed tests, surgical procedures, and medication

Life-Sustaining Treatment:

_____☑ I grant my attorney in fact the authority to consent to the withholding or withdrawing of life-sustaining treatment if I am suffering from a terminal condition or in a persistent vegetative state.

Limitations on Attorney in Fact's Authority:

I do not wish to limit the authority of my attorney in fact at this time.

PART II: DECLARATION

I do not wish to execute a declaration governing the withholding or withdrawal of life-sustaining treatment at this time.

ADDITIONAL INSTRUCTIONS.

I do not wish to leave additional instructions at this time.

SIGNATURES

This document must be signed and dated by me. It also must either be verified by two witnesses (Option 1) OR a notary public (Option 2). It must be signed and dated when it is witnessed or verified. No more than one witness may be an administrator or employee of a health care provider who is caring for or treating me.

I, FirstName LastName, sign this directive 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 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 an employee of a life or health insurance provider for the declarant.
- I am not the principal's spouse, parent, child, grandchild, or sibling.
- I am not the principal's romantic or dating partner.
- I am not the principal's presumptive heir or known devisee.
- I am not the principal's attending physician or mental health treatment team member.
- I am not named as an attorney in fact or an alternate attorney in fact in this document.
- I am not an employee of a life or health insurance provider for the principal.

Witness One Signature: ____

Witness One Printed Name: _______________________________________

Witness One Address: ____

____

Witness One Phone: ____

Witness Two. 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. I certify the following:

- I am not an employee of a life or health insurance provider for the declarant.
- I am not the principal's spouse, parent, child, grandchild, or sibling.
- I am not the principal's romantic or dating partner.
- I am not the principal's presumptive heir or known devisee.
- I am not the principal's attending physician or mental health treatment team member.
- I am not named as an attorney in fact or an alternate attorney in fact in this document.

- I am not an employee of a life or health insurance provider for the principal.
- I am not an administrator or employee of a health care provider who is caring for or treating the principal.

Witness Two Signature: ____

Witness Two Printed Name: ____________________________________

Witness Two Address: ____

____

Witness Two Phone: ____

OR

NOTARY PUBLIC (OPTION 2)

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.

- I am not named as an attorney in fact or alternate attorney in fact in this document.

Notary Public Signature: ______________________________________

Commission Expiration Date: ___________________________________