# Power of Attorney For Health Care

I appoint,_________________________________________________, whose address is _________________________________________________, and whose telephone number is (____) _________________________, as my attorney-in fact for health care. I appoint _______________________________, whose address is ______________________________, whose telephone number is (_____)____________________, as my successor attorney-in fact for health care. I authorize my attorney-in fact appointed by this document to make heath care decisions for me when I am determined to be incapable of making my own health care decisions.

I direct that my attorney-in-fact comply with the following instructions or limitations:

_____________________________________________________________________________________

_____________________________________________________________________________________

_________________________________________________________________

I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment:

_____________________________________________________________________________________

_____________________________________________________________________________________

_________________________________________________________________

I instruct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:

_____________________________________________________________________________________

_____________________________________________________________________________________

_________________________________________________________________

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 ATTONREY 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 HEATLH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Dated this ____ day of ____________, 20_____

_____________________________________________

Signature of Principal

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, and that (he/she) signed (his/her) signature on this power of attorney for health care in our presence; that (he/she) 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) | (Printed Name of Witness) |
| | ______________________________ |
| | (Address) |
| ___________________________________ | ______________________________ |
| (Date) | |

| | |
|---|---|
| ___________________________________ | ___________________________________ |
| (Signature of Witness) | (Printed Name of Witness) |
| | ______________________________ |
| | (Address) |
| ___________________________________ | ______________________________ |
| (Date) | |

**OR**

State of Nebraska )<br>
)ss<br>
County Of ______)

On this _____day of _________________, 20_____, before me, a notary public in and for the State of Nebraska, personally to me known to be the identical person whose name is affixed to the above power of attorney for heath care as principal, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this power of attorney for health care.

Witness my hand and notarial seal in such county the day and year last above written.

______________________________________

Notary Public