

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*. 1996;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 professionals 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:

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~ Lifecare Directives ~



*Statutory
Advance Directive
For
Nevada Residents*



*Statutory Compliant
Advance Directive for
Health Care Choices*

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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 warranted 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 Nevada 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 Nevada state 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 sufficient 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

(NRS Title 40: Ch. 449: §449.535 to §449.690)

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1. INTRODUCTION: *The Nevada State Living Will was designed to assist those wishing to refuse life-sustaining treatment in a terminal condition (§449.610). Before completing the directive, you should be aware of key terms and definitions. A **terminal condition** is defined as, “an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.” (§449.590). **Life-sustaining treatment** is defined as, “a medical procedure or intervention that, when administered to a patient, serves only to prolong the process of dying” (§449.570).*

DECLARATION

2. If I should 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 NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.
3. If you wish to include the following statement in this declaration, you must INITIAL the statement on the line provided:

4. _____ Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld pursuant to this declaration.

(Sign in the presence of two adult witnesses; see below)

5. Signed this _____ day of _____, 20 _____

6. Signature: _____

7. Address: _____

Statement of Witnesses

8. The declarant voluntarily signed this writing in my presence.

9. Witness: _____

Printed Name: _____

Address: _____

10. Witness: _____

Printed Name: _____

Address: _____

SECTION II:
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

(NRS Title 40: Ch.449: §449.800 to §449-860)

11. 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 counsel and advice.*

DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

A. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE 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. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

B. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

D. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

E. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

F. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

G. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING

THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

H. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

I. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

J. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

12. DESIGNATION OF HEALTH CARE AGENT.

13. Be it known that I:

Full Legal Name: _____

Date of Birth: _____

Residence Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ do hereby designate and appoint:

14. **Name of Agent:** _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

~~ as my attorney-in-fact to make health care decisions for me as authorized in this document. *(Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: 1) your treating provider of health care, 2) an employee of your treating provider of health care, 3) an operator of a health care facility, or 4) an employee of an operator of a health care facility. Your agent must also sign an acceptance of this appointment on page 22.)*

15. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

16. 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 attorney-in-fact 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, subject only to the limitations and special provisions, if any, set forth in paragraph 17, 19 and 25.

17. SPECIAL PROVISIONS AND LIMITATIONS. *(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations: _____

18. DURATION. I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself. *(IF APPLICABLE)*

I wish this power of attorney to end on the following date: _____

19. STATEMENT OF DESIRES. *(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. 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.)*

(If the statement reflects your desires, initial the box next to the statement.)

20. _____ 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.

21. _____ If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)*

22. _____ 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. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed).*
23. _____ Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld.
24. _____ I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

(If you wish to change an answer, above, you may do so by drawing an "X" through the answer you do not want, and circling and initialing the answer you prefer.)

25. Other or Additional Statements of Desires: _____

26. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT. *(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)*

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. *First Alternative Attorney-in-fact*

Name: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

B. *Second Alternative Attorney-in-fact*

Name: _____
Address: _____
Telephone: Home: _____ Work: _____
Cell Phone or Pager: _____ E-mail: _____

27. PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.
(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

28. I sign my name to this Durable Power of Attorney for Health care on:

(date) _____

at (city / state) _____

29. (Signature) _____

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

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

30. State of NEVADA,

County of _____ }
}

On this _____ day of _____, in the year _____, before me,
_____ (insert name of notary public) personally appeared
_____ (insert name of principal) personally known to me
(or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

(Signature of Notary Public)

SEAL:

Date Commission Expires

STATEMENT OF WITNESSES *(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact, (2) a provider of health care, (3) an employee of a provider of health care, (4) the operator of a health care facility, (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)*

31. I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

32. Witness #A: Signature: _____
Date: _____
Print Name: _____
Residence Address: _____

33. Witness #B: Signature: _____
Date: _____
Print Name: _____
Residence Address: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION)

34. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I have no claim against and I am not entitled to any part of the estate of the principal upon the death of the principal under a will or codicil now existing or by any other operation of law.

Witness #A: Signature: _____

Witness #B: Signature: _____

35. COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.