Nebraska Living Will Declaration

If I should lapse into a persistent vegetative state or 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 the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Other directions: _____

_____

_____

_____

Signed this _____ day of _____

Signature _____

Address _____

_____

The declarant voluntarily signed this writing in my presence.

Witness _____

Address _____

_____

Witness _____

Address _____

_____

OR

The declarant voluntarily signed this writing in my presence.

_____

Notary Public

NEBRASKA
POWER OF ATTORNEY FOR HEALTH CARE

1. I appoint _____,

   whose address is _____

   and whose telephone number is _____
   as my attorney-in-fact for health care.

   I appoint _____,

   whose address is _____

   and 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 health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

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

   _____

   _____

   _____

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

   (optional) _____

   _____

   _____

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

   (optional) _____

   _____

   _____

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 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.

_____

(Signature of person making designation/date)

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, and 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

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 power of attorney for health care as principal, and I declare 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 at _____ in such county the day and year last above written.

_____

Notary Public