ASSEMBLY BILL NO. 128–COMMITTEE ON JUDICIARY

(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON SENIOR CITIZENS, VETERANS AND ADULTS WITH SPECIAL NEEDS)

FEBRUARY 6, 2015

Referred to Committee on Judiciary

SUMMARY-Creates a power of attorney for health care decisions adults with intellectual for disabilities. (BDR 13-418)

FISCAL NOTE: Effect on Local Government: No. Effect on the State: No.

EXPLANATION - Matter in *bolded italics* is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and italics is new; matter between brackets for ital and ital

AN ACT relating to powers of attorney; creating a power of attorney for health care decisions for adults with intellectual disabilities; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law sets forth provisions governing durable powers of attorney for health care decisions. (NRS 162A.700-162A.860) Existing law specifically provides an example of a form for a power of attorney for health care. (NRS 162A.860) Section 3 of this bill provides examples of a form for a power of attorney for health care for adults with intellectual disabilities and a form for 1 2 3 4 5 end-of-life decisions for adults with intellectual disabilities

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 162A of NRS is hereby amended by 1 adding thereto the provisions set forth as sections 2 and 3 of this act. 2 Sec. 2. *"Intellectual* disability" 3 means significantly **Sec. 2.** "Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently 4 with deficits in adaptive behavior and manifested during the 5 developmental period. 6





1 Sec. 3. 1. The form of a power of attorney for health care 2 for an adult with an intellectual disability may be substantially in 3 the following form, and must be witnessed or executed in the same 4 manner as the following form: 5

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

9 My name is...... (insert your name) and my 10 address is...... (insert your address). I would like to 11 designate...... (insert the name of the person you 12 wish to designate as your agent for health care decisions for 13 you) as my agent for health care decisions for me if I am 14 sick or hurt and need to see a doctor or go to the hospital. I 15 understand what this means.

16 If I am sick or hurt, my agent should take me to the 17 doctor. If my agent is not with me when I become sick or 18 hurt, please contact my agent and ask him or her to come to 19 the doctor's office. I would like the doctor to speak with my 20 agent and me about my sickness or injury and whether I need any medicine or other treatment. After we speak with 21 22 the doctor, I would like my agent to speak with me about the 23 care or treatment. When we have made decisions about the care or treatment, my agent will tell the doctor about our 24 25 decisions and sign any necessary papers.

If I am very sick or hurt, I may need to go to the hospital. 26 27 I would like my agent to help me decide if I need to go to the hospital. If I go to the hospital, I would like the people who 28 29 work at the hospital to try very hard to care for me. If I am 30 able to communicate, I would like the doctor at the hospital 31 to speak with me and my agent about what care or treatment 32 I should receive, even if I am unable to understand what is 33 being said about me. After we speak with the doctor, I would like my agent to help me decide what care or treatment I 34 35 should receive. Once we decide, my agent will sign any necessary paperwork. If I am unable to communicate 36 because of my illness or injury, I would like my agent to 37 38 make decisions about my care or treatment based on what 39 he or she thinks I would do and what is best for me. 40

I would like my agent to help me decide if I need to see a dentist and help me make decisions about what care or treatment I should receive from the dentist. Once we decide, my agent will sign any necessary paperwork.

I would also like my agent to be able to see and have copies of all my medical records. If my agent requests to see



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1	or have copies of my medical records, please allow him or
2	her to see or have copies of the records.
3	I understand that my agent cannot make me receive any
4	care or treatment that I do not want. I also understand that
5	I can take away this power from my agent at any time,
6	either by telling him or her that they are no longer my agent
7	or by putting it in writing.
8	If my agent is unable to make health care decisions for
9	me, then I designate (insert the name of another
10	person you wish to designate as your alternative agent to
11	make health care decisions for you) as my agent to make
12	health care decisions for me as authorized in this document.
13	
14	(YOU MUST DATE AND SIGN THIS
15	POWER OF ATTORNEY)
16	
17	I sign my name to this Durable Power of Attorney for
18	Health Care on (date) at
19	(city), (state)
20	
21	(Signature)
22	
23	AGENT SIGNATURE
24	
25	As agent for (insert name of principal), I agree
26	that a physician, health care facility or other provider of
27	health care, acting in good faith, may rely on this power of
28	attorney for health care and the signatures herein, and I
29	understand that pursuant to NRS 162A.815, a physician,
30	health care facility or other provider of health care that in
31	good faith accepts an acknowledged power of attorney for
32	health care is not subject to civil or criminal liability or
33	discipline for unprofessional conduct for giving effect to a
34	declaration contained within the nower of attorney for
35	declaration contained within the power of attorney for
	health care or for following the direction of an agent named
36	health care or for following the direction of an agent named in the power of attorney for health care.
37	health care or for following the direction of an agent named in the power of attorney for health care. I also agree that:
37 38	health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: 1. I have a duty to act in a manner consistent with the
37 38 39	health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: 1. I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this
37 38 39 40	 health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: I have a duty to act in a manner consistent with the desires of
37 38 39 40 41	 health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this document or otherwise made known by
37 38 39 40 41 42	health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: 1. I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this document or otherwise made known by (insert name of principal), or if his or her desires are unknown, to act in his or her best interest.
37 38 39 40 41 42 43	 health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this document or otherwise made known by (insert name of principal), or if his or her desires are unknown, to act in his or her best interest. I f
37 38 39 40 41 42 43 44	 health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this document or otherwise made known by (insert name of principal), or if his or her desires are unknown, to act in his or her best interest. If
37 38 39 40 41 42 43	 health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this document or otherwise made known by (insert name of principal), or if his or her desires are unknown, to act in his or her best interest. I f
37 38 39 40 41 42 43 44	 health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this document or otherwise made known by
37 38 39 40 41 42 43 44	 health care or for following the direction of an agent named in the power of attorney for health care. I also agree that: I have a duty to act in a manner consistent with the desires of (insert name of principal) as stated in this document or otherwise made known by

	and the second
1	document, including, without limitation, treating
2	physicians, hospital staff or other providers of health care,
3	that I no longer have the authorities described in this
4	document.
5	3. The provisions of NRS 162A.840 prohibit me from
6	being named as an agent to make health care decisions in
7	this document if I am a provider of health care, an
8	employee of the principal's provider of health care or an
9	operator or employee of a health care facility caring for the
10	principal, unless I am the spouse, legal guardian or next of
11	kin of the principal.
12	4. The provisions of NRS 162A.850 prohibit me from
13	consenting to the following types of care or treatments on
14	behalf of the principal, including, without limitation:
14	(a) Commitment or placement of the principal in a
15	(a) Commument of placement of the principal in a
10	facility for treatment of mental illness;
17	(b) Convulsive treatment;
18	(c) Psychosurgery;
19	(d) Sterilization;
20	(e) Abortion;
21	(f) Aversive intervention, as it is defined in
22	NRS 449.766;
23	(g) Experimental medical, biomedical or behavioral
24	treatment, or participation in any medical, biomedical or
25	behavioral research program; or
26	(h) Any other care or treatment to which the principal
27	prohibits the agent from consenting in this document.
28	5. End-of-life decisions must be made according to the
29	wishes of (insert name of principal), as designated in
30	the attached addendum. If his or her wishes are not known,
31	such decisions must be made in consultation with the
32	principal's treating physicians.
33	1
34	Signature: Residence Address:
35	Print Name:
36	Date:
37	Relationship to principal:
38	Length of relationship to principal:
38 39	Lengin of remainship to principul
39 40	(THIS POWER OF ATTORNEY WILL NOT BE VALID
40 41	FOR MAKING HEALTH CARE DECISIONS UNLESS IT
42	IS EITHER (1) SIGNED BY AT LEAST TWO
43	QUALIFIED WITNESSES WHO YOU KNOW AND WHO
44	ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE





4 **CERTIFICATE OF ACKNOWLEDGMENT** 5 **OF NOTARY PUBLIC** 6 7 (You may use acknowledgment before a notary public instead of the statement of witnesses.) 8 9 10 State of Nevada } }ss. 11 12 County of..... 13 14 On this...... day of....., in the year...., before me,..... (here insert name of notary public) personally 15 appeared...... (here insert name of principal) personally 16 known to me (or proved to me on the basis of satisfactory 17 evidence) to be the person whose name is subscribed to this 18 instrument, and acknowledged that he or she executed it. I 19 declare under penalty of perjury that the person whose 20 name is ascribed to this instrument appears to be of sound 21 mind and under no duress, fraud or undue influence. 22 23 24 NOTARY SEAL (Signature) 25 26 27 STATEMENT OF WITNESSES 28 29 (If you choose to use witnesses instead of having this document notarized, you must use two qualified adult 30 witnesses. The following people cannot be used as a witness: 31 (1) a person you designate as the agent; (2) a provider of 32 health care; (3) an employee of a provider of health care; 33 (4) the operator of a health care facility; or (5) an employee 34 of an operator of a health care facility. At least one of the 35 witnesses must make the additional declaration set out 36 following the place where the witnesses sign.) 37

38I declare under penalty of perjury that the principal is39personally known to me, that the principal signed or40acknowledged this durable power of attorney in my41presence, that the principal appears to be of sound mind42and under no duress, fraud or undue influence, that I am43not the person appointed as agent by this document and that44I am not a provider of health care, an employee of a



1 2

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A NOTARY PUBLIC.)

YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE

1 2	provider of health care, the operator of a health care facility or an employee of an operator of a health care facility.	
3		
4	Signature: Residence Address:	
5	Print Name:	
6	Date:	
7		
8	Signature: Residence Address:	
9	Print Name:	
10	Date:	
11		
12	(AT LEAST ONE OF THE ABOVE WITNESSES	
13	MUST ALSO SIGN THE FOLLOWING DECLARATION.)	
14		
14	I declare under penalty of perjury that I am not related	
16	to the principal by blood, marriage or adoption and that to	
17	the best of my knowledge, I am not entitled to any part of	
18	the estate of the principal upon the death of the principal	
19	under a will now existing or by operation of law.	
20	G ¹	
21	Signature:	
22	Signature:	
23		
24	Names: Address:	
25	Print Name:	
26	Date:	
27		
28	COPIES: You should retain an executed copy of this	
29	document and give one to your agent. The power of attorney	
30	should be available so a copy may be given to your providers	
31	of health care.	
32		
33	2. The form for end-of-life decisions of a power of attorney	
34	for health care for an adult with an intellectual disability may be	
35	substantially in the following form, and must be witnessed or	
36	executed in the same manner as the following form:	
37		
38	END-OF-LIFE DECISIONS ADDENDUM	
39	STATEMENT OF DESIRES	
40		
41	(You can, but are not required to, state what you want to	
42	happen if you get very sick and are not likely to get well.	
43	You do not have to complete this form, but if you do, your	
44	agent must do as you ask if you cannot speak for yourself.)	
	* * *	
	**** * * * * * * * * * * * * * * * * *	

1 2	(Insert name of agent) might have to decide, if you get very sick, whether to continue with your medicine or			
3	to stop your medicine, even if it n	ieans you n	night not	
4	live (Insert name of age	nt) will talk	to you to	
5	find out what you want to do, and will	follow your v	vishes.	
6				
7	If you are not able to talk to			
8	agent), you can help him or her mai		isions for	
9	you by letting your agent know what you want.			
10				
11	Here are your choices. Please circle yo	Here are your choices. Please circle yes or no to each of the		
12	following statements and sign your na	me below:		
13				
14	1. I want to take all the			
15	medicine and receive any			
16	treatment I can to keep me alive			
17	regardless of how the medicine or			
18	treatment makes me feel.	YES	NO	
19	2. I do not want to take			
20	medicine or receive treatment if			
21	my doctors think that the			
22	medicine or treatment will not			
23	help me.	YES	<i>N0</i>	
24	3. I do not want to take			
25	medicine or receive treatment if I			
26	am very sick and suffering and			
27	the medicine or treatment will not			
28	help me get better.	YES	NO	
29	4. I want to get food and	125	110	
30	water even if I do not want to take			
31	medicine or receive treatment.	YES	NO	
32	memente of receive treatment.	TLS	110	
33	(YOU MUST DATE AND SIGN TH	IIS END-OF	LIFE	
34	DECISIONS ADDEN			
35				
36	I sign my name to this Fnd-of-Life	Decisions A	ddendum	
37	I sign my name to this End-of-Life Decisions Addendum on (date) at (city), (state)			
38	<i>on</i>		uicj	
39	(Signature)			
40	(Signum e)			
40 41	(THIS END_OF_LIFE DECISIONS	ADDENDI	M WILL	
41	(THIS END-OF-LIFE DECISIONS ADDENDUM WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY			
42	AT LEAST TWO QUALIFIED WITNESSES WHO YOU			
43 44	KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR			
	ANO WILL WILL ARE I RESERVEN			
	* * * *			





(2) 1 ACKNOWLEDGE YOUR **SIGNATURE** OR 2 ACKNOWLEDGED BEFORE A NOTARY PUBLIC.) 3 4 **CERTIFICATE OF ACKNOWLEDGMENT** 5 **OF NOTARY PUBLIC** 6 7 (You may use acknowledgment before a notary public instead of the statement of witnesses.) 8 9 10 State of Nevada }ss. 11 12 County of..... 13 14 On this...... day of....., in the year...., before me,..... (here insert name of notary public) personally 15 appeared...... (here insert name of principal) personally 16 known to me (or proved to me on the basis of satisfactory 17 evidence) to be the person whose name is subscribed to 18 this instrument, and acknowledged that he or she executed 19 it. I declare under penalty of perjury that the person 20 whose name is ascribed to this instrument appears to be 21 of sound mind and under no duress, fraud or undue 22 23 influence. 24 25 **NOTARY SEAL** 26 (Signature) 27 28 STATEMENT OF WITNESSES 29 (If you choose to use witnesses instead of having this 30 document notarized, you must use two qualified adult 31 witnesses. The following people cannot be used as a witness: 32 (1) a person you designate as the agent; (2) a provider of 33 health care; (3) an employee of a provider of health care; 34 (4) the operator of a health care facility; or (5) an employee 35 of an operator of a health care facility. At least one of the 36 witnesses must make the additional declaration set out 37 following the place where the witnesses sign.) 38 I declare under penalty of perjury that the principal is 39 personally known to me, that the principal signed or 40 acknowledged this End-of-Life Decisions Addendum in my 41 42 presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am 43 not the person appointed as agent by the power of attorney 44 for health care and that I am not a provider of health care, 45





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1		of health care, the operator of a	
2		employee of an operator of a	
3	health care facility.		
4			
5	Signature:	Residence Address:	
6	Print Name:		
7	Date:		
8	2		
9	Signature:	Residence Address:	
10	Print Name:	Restuence mun ess	
11	Date:	••••••	
	Dule		
12			
13		F THE ABOVE WITNESSES	
14	MUST ALSO SIGN THE F	COLLOWING DECLARATION.)	
15			
16	I declare under pena	lty of perjury that I am not	
17	related to the principal by	blood, marriage or adoption and	
18	that to the best of my know	wledge, I am not entitled to any	
19	part of the estate of the principal upon the death of the		
20	principal under a will no	principal under a will now existing or by operation of	
21	law.		
22			
	Signature:		
23			
23 24			
24	Signature:		
24 25	Signature:	Adduces	
24 25 26	Signature: Names:	Address:	
24 25 26 27	Signature: Names: Print Name:	Address:	
24 25 26 27 28	Signature: Names:		
24 25 26 27 28 29	Signature: Names: Print Name: Date:		
24 25 26 27 28 29 30	Signature: Names: Print Name: Date: COPIES: You should ret	tain an executed copy of this	
24 25 26 27 28 29 30 31	Signature: Names: Print Name: Date: COPIES: You should ret document and give one t	tain an executed copy of this o your agent. The End-of-Life	
24 25 26 27 28 29 30	Signature: Names: Print Name: Date: COPIES: You should rea document and give one to Decisions Addendum should	tain an executed copy of this o your agent. The End-of-Life Id be available so a copy may be	
24 25 26 27 28 29 30 31	Signature: Names: Print Name: Date: COPIES: You should rea document and give one to Decisions Addendum shoul given to your providers of h	tain an executed copy of this o your agent. The End-of-Life ld be available so a copy may be ealth care.	
24 25 26 27 28 29 30 31 32	Signature: Names: Print Name: Date: COPIES: You should read document and give one to Decisions Addendum should given to your providers of h Sec. 4. NRS 162A.700 is here	tain an executed copy of this o your agent. The End-of-Life Id be available so a copy may be ealth care. eby amended to read as follows:	
24 25 26 27 28 29 30 31 32 33	Signature: Names: Print Name: Date: COPIES: You should read document and give one to Decisions Addendum should given to your providers of h Sec. 4. NRS 162A.700 is here	tain an executed copy of this o your agent. The End-of-Life Id be available so a copy may be ealth care. eby amended to read as follows:	
24 25 26 27 28 29 30 31 32 33 34 35	Signature: Names: Print Name: Date: COPIES: You should read document and give one to Decisions Addendum shoul given to your providers of h Sec. 4. NRS 162A.700 is here 162A.700 NRS 162A.700 to	tain an executed copy of this o your agent. The End-of-Life Id be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive,	
24 25 26 27 28 29 30 31 32 33 34 35 36	Signature: Names: Print Name: Date: COPIES: You should ret document and give one to Decisions Addendum shout given to your providers of h Sec. 4. NRS 162A.700 is her 162A.700 NRS 162A.700 to and section 2 of this act apply to	tain an executed copy of this o your agent. The End-of-Life Id be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing	
24 25 26 27 28 29 30 31 32 33 34 35 36 37	Signature:	tain an executed copy of this o your agent. The End-of-Life d be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing ecisions.	
24 25 26 27 28 29 30 31 32 33 34 35 36 37 38	Signature:	tain an executed copy of this o your agent. The End-of-Life d be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing ecisions. eby amended to read as follows:	
24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39	Signature:	tain an executed copy of this o your agent. The End-of-Life d be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing ecisions. eby amended to read as follows: 62A.700 to 162A.860, inclusive,	
24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40	Signature:	tain an executed copy of this o your agent. The End-of-Life d be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing ecisions. eby amended to read as follows: 62A.700 to 162A.860, inclusive, ct, unless the context otherwise	
24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41	Signature:	tain an executed copy of this o your agent. The End-of-Life d be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing ecisions. eby amended to read as follows: 62A.700 to 162A.860, inclusive, ct, unless the context otherwise defined in NRS 162A.720 to	
24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42	Signature:	tain an executed copy of this o your agent. The End-of-Life d be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing ecisions. eby amended to read as follows: 62A.700 to 162A.860, inclusive, ct, unless the context otherwise defined in NRS 162A.720 to	
24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41	Signature:	tain an executed copy of this o your agent. The End-of-Life d be available so a copy may be ealth care. eby amended to read as follows: [162A.860,] 162A.850, inclusive, any power of attorney containing ecisions. eby amended to read as follows: 62A.700 to 162A.860, inclusive, ct, unless the context otherwise defined in NRS 162A.720 to	





1	Sec. 6. NRS 162A.860 is hereby amended to read as follows:			
2	162A.860 [The] Except as otherwise provided in section 3 of			
3 4	this act, the form of a power of attorney for health care may be			
4 5	substantially in the following form, and must be witnessed or executed in the same manner as the following form:			
6	executed in the same manner as the following form.			
7	DURABLE POWER OF ATTORNEY			
8	FOR HEALTH CARE DECISIONS			
9				
10	WARNING TO PERSON EXECUTING THIS DOCUMENT			
11				
12	THIS IS AN IMPORTANT LEGAL DOCUMENT. IT			
13	CREATES A DURABLE POWER OF ATTORNEY FOR			
14	HEALTH CARE. BEFORE EXECUTING THIS			
15	DOCUMENT, YOU SHOULD KNOW THESE			
16	IMPORTANT FACTS:			
17	1. THIS DOCUMENT GIVES THE PERSON YOU			
18	DESIGNATE AS YOUR AGENT THE POWER TO MAKE			
19 20	HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF			
20 21	YOUR DESIRES THAT YOU INCLUDE IN THIS			
$\frac{21}{22}$	DOCUMENT. THE POWER TO MAKE HEALTH CARE			
$\frac{22}{23}$	DECISIONS FOR YOU MAY INCLUDE CONSENT,			
24	REFUSAL OF CONSENT OR WITHDRAWAL OF			
25	CONSENT TO ANY CARE, TREATMENT, SERVICE OR			
26	PROCEDURE TO MAINTAIN, DIAGNOSE OR TREAT A			
27	PHYSICAL OR MENTAL CONDITION. YOU MAY			
28	STATE IN THIS DOCUMENT ANY TYPES OF			
29	TREATMENT OR PLACEMENTS THAT YOU DO NOT			
30	DESIRE.			
31	2. THE PERSON YOU DESIGNATE IN THIS			
32	DOCUMENT HAS A DUTY TO ACT CONSISTENT			
33	WITH YOUR DESIRES AS STATED IN THIS			
34	DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR			
35 36	BEST INTERESTS.			
30 37	3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS			
38	DOCUMENT, THE POWER OF THE PERSON YOU			
39	DESIGNATE TO MAKE HEALTH CARE DECISIONS			
40	FOR YOU MAY INCLUDE THE POWER TO CONSENT			
41	TO YOUR DOCTOR NOT GIVING TREATMENT OR			
42	STOPPING TREATMENT WHICH WOULD KEEP YOU			
43	ALIVE.			
44	4. UNLESS YOU SPECIFY A SHORTER PERIOD IN			
45	THIS DOCUMENT, THIS POWER WILL EXIST			





1	INDEFINITELY FROM THE DATE YOU EXECUTE THIS
2	DOCUMENT AND, IF YOU ARE UNABLE TO MAKE
3	HEALTH CARE DECISIONS FOR YOURSELF, THIS
4	POWER WILL CONTINUE TO EXIST UNTIL THE TIME
5	WHEN YOU BECOME ABLE TO MAKE HEALTH CARE
6	DECISIONS FOR YOURSELF.
7	
	5. NOTWITHSTANDING THIS DOCUMENT, YOU
8	HAVE THE RIGHT TO MAKE MEDICAL AND OTHER
9	HEALTH CARE DECISIONS FOR YOURSELF SO LONG
10	AS YOU CAN GIVE INFORMED CONSENT WITH
11	RESPECT TO THE PARTICULAR DECISION. IN
12	ADDITION, NO TREATMENT MAY BE GIVEN TO YOU
13	OVER YOUR OBJECTION, AND HEALTH CARE
14	NECESSARY TO KEEP YOU ALIVE MAY NOT BE
15	STOPPED IF YOU OBJECT.
16	6. YOU HAVE THE RIGHT TO REVOKE THE
17	APPOINTMENT OF THE PERSON DESIGNATED IN
18	THIS DOCUMENT TO MAKE HEALTH CARE
	DECISIONS FOR YOU BY NOTIFYING THAT PERSON
19	
20	OF THE REVOCATION ORALLY OR IN WRITING.
21	7. YOU HAVE THE RIGHT TO REVOKE THE
22	AUTHORITY GRANTED TO THE PERSON
23	DESIGNATED IN THIS DOCUMENT TO MAKE
24	HEALTH CARE DECISIONS FOR YOU BY NOTIFYING
25	THE TREATING PHYSICIAN, HOSPITAL OR OTHER
26	PROVIDER OF HEALTH CARE ORALLY OR IN
27	WRITING.
28	8. THE PERSON DESIGNATED IN THIS
29	DOCUMENT TO MAKE HEALTH CARE DECISIONS
30	FOR YOU HAS THE RIGHT TO EXAMINE YOUR
31	MEDICAL RECORDS AND TO CONSENT TO THEIR
	DISCLOSUDE UNLESS VOL LIMIT THIS DISCUT IN
32	DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN
33	THIS DOCUMENT.
34	9. THIS DOCUMENT REVOKES ANY PRIOR
35	DURABLE POWER OF ATTORNEY FOR HEALTH
36	CARE
37	10. IF THERE IS ANYTHING IN THIS DOCUMENT
38	THAT YOU DO NOT UNDERSTAND, YOU SHOULD
39	ASK A LAWYER TO EXPLAIN IT TO YOU.
40	
41	1. DESIGNATION OF HEALTH CARE AGENT.
42	Ι
43	(insert your name) do hereby designate and appoint:
15	(inserv your nume) do nereoy designate and appoint.





Name: Address: Telephone Number:

as my agent to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your agent to make health care decisions for you. 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 agent: (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.)

CREATION OF DURABLE POWER OF
 ATTORNEY FOR HEALTH CARE.
 By this document I intend to create a durable power of

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.

22 3. GENÉRĂL STATEMENT OF AUTHORITY 23 GRANTED.

24 In the event that I am incapable of giving informed 25 consent with respect to health care decisions. I hereby grant 26 to the agent named above full power and authority: to make health care decisions for me before or after my death. 27 including consent, refusal of consent or withdrawal of 28 29 consent to any care, treatment, service or procedure to 30 maintain, diagnose or treat a physical or mental condition; to 31 request, review and receive any information, verbal or written, regarding my physical or mental health, including, 32 without limitation, medical and hospital records; to execute 33 on my behalf any releases or other documents that may be 34 required to obtain medical care and/or medical and 35 hospital records, EXCEPT any power to enter into any 36 37 arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility 38 including any skilled nursing facility; and subject only to the 39 limitations and special provisions, if any, set forth in 40 41 paragraph 4 or 6.

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4. SPECIAL PROVISIONS AND LIMITATIONS.

(Your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery,





1 2 3 4 5 6	sterilization or abortion. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for or other restrictions you wish to place on his or her agent's authority, you should list them in the space below. If you do not write any limitations, your agent will have the broad powers to make health
7 8	care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by
9	law.)
10	In exercising the authority under this durable power of
11	attorney for health care, the authority of my agent is subject
12	to the following special provisions and limitations:
13	
14	
15 16	
16	
17	5. DURATION.
18	I understand that this power of attorney will exist
20	indefinitely from the date I execute this document unless I
20	establish a shorter time. If I am unable to make health care
22	decisions for myself when this power of attorney expires, the
23	authority I have granted my agent will continue to exist until
24	the time when I become able to make health care decisions
25	for myself.
26	
27	(IF APPLICABLE)
28	I wish to have this power of attorney end on the
29	following date:
30 31	6. STATEMENT OF DESIRES.
31	(With respect to decisions to withhold or withdraw life-
32	sustaining treatment, your agent must make health care
34	decisions that are consistent with your known desires. You
35	can, but are not required to, indicate your desires below. If
36	your desires are unknown, your agent has the duty to act in
37	your best interests; and, under some circumstances, a judicial
38	proceeding may be necessary so that a court can determine
39	the health care decision that is in your best interests. If you
40	wish to indicate your desires, you may INITIAL the statement
41	or statements that reflect your desires and/or write your own
42	statements in the space below.)





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

1. 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.

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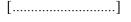
11

12 2. If I am in a coma which my 13 doctors have reasonably concluded 14 is irreversible, I desire that 15 life-sustaining or prolonging 16 treatments not be used. (Also 17 should utilize provisions of NRS 18 449.535 to 449.690, inclusive, if this subparagraph is initialed.) 19

20 3. If I have an incurable or 21 terminal condition or illness and 22 no reasonable hope of long-term recovery or survival, I desire 23 that life-sustaining or prolonging 24 25 treatments not be used. (Also should utilize provisions of NRS 26 449.535 to 449.690, inclusive, if 27 28 this subparagraph is initialed.)

29 Withholding or withdrawal 4. 30 of artificial nutrition and hydration 31 may result in death by starvation 32 or dehydration. I want to receive 33 or continue receiving artificial 34 nutrition and hydration by way of 35 the gastrointestinal tract after all other treatment is withheld. 36

37 5. I do not desire treatment to be provided and/or continued if the 38 39 burdens of the treatment outweigh 40 the expected benefits. My agent is 41 to consider the relief of suffering, 42 the preservation or restoration of 43 functioning, and the quality as well 44 as the extent of the possible 45 extension of my life.



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[.....]

[.....]

[....]

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1 2	(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and			
$\frac{2}{3}$	circling the answer you prefer.)			
4	Other or Additional Statements of Desires:			
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11	7. DESIGNATION OF ALTERNATE AGENT.			
12	(You are not required to designate any alternative agent			
13	but you may do so. Any alternative agent you designate will			
14	be able to make the same health care decisions as the agent			
15	designated in paragraph 1, page 2, in the event that he or she			
16	is unable or unwilling to act as your agent. Also, if the agent			
17	designated in paragraph 1 is your spouse, his or her			
18	designation as your agent is automatically revoked by law if			
19	your marriage is dissolved.)			
20	If the person designated in paragraph 1 as my agent is			
21	unable to make health care decisions for me, then I designate			
22	the following persons to serve as my agent to make health			
23	care decisions for me as authorized in this document, such			
24	persons to serve in the order listed below:			
25				
26	A. First Alternative Agent			
27	Name:			
28	Address:			
29	Telephone Number:			
30				
31	B. Second Alternative Agent			
32	Name:			
33	Address:			
34	Telephone Number:			
35				
36	8. PRIOR DESIGNATIONS REVOKED.			
37	I revoke any prior durable power of attorney for health			
38	Care.			
39 40	9. WAIVER OF CONFLICT OF INTEREST.			
40 41	If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out			
41 42	the provisions of this Durable Power of Attorney for Health			
42 43	Care that said spouse or child may have by reason of the fact			
43 44	that he or she may be a beneficiary of my estate.			
-1-1	that he of she may be a beneficiary of my estate.			





$ \begin{array}{c} 1\\2\\3\\4\\5\\6\\7\\8\\9\\10\\11\\12\\13\\14\\15\\16\\17\\18\\19\\20\\21\\22\\23\\24\\25\end{array} $	 10. CHALLENGES. If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, 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 Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada. 11. NOMINATION OF GUARDIAN. If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings 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. 12. 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, Public Law 104-191, as amended, and applicable regulations.
26 27 28 29	I sign my name to this Durable Power of Attorney for Health Care on (date) at (city), (state)
30 31	(Signature)
32 33 34 35 36 37 38 39 40	(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.)
41 42	CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC
43 44 45	(You may use acknowledgment before a notary public instead of the statement of witnesses.)
	* A B 1 2 8 R 1 *

1	State of Nevada }		
2	§ss.		
3 4	County of		
5	On this day of, in the year, before		
6	me, (here insert name of notary public)		
7 8	personally appeared (here insert name of principal) personally known to me (or proved to me on the		
9	basis of satisfactory evidence) to be the person whose name is		
10	subscribed to this instrument, and acknowledged that he or		
11 12	she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to		
12	be of sound mind and under no duress, fraud or undue		
14	influence.		
15 16	NOTARY SEAL		
17	(Signature of Notary Public)		
18			
19 20	STATEMENT OF WITNESSES		
20	(You should carefully read and follow this witnessing		
22	procedure. This document will not be valid unless you		
23 24	comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you		
2 4 25	must use two qualified adult witnesses. None of the following		
26	may be used as a witness: (1) a person you designate as the		
27 28	agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care		
20 29	facility; or (5) an employee of an operator of a health care		
30	facility. At least one of the witnesses must make the		
31 32	additional declaration set out following the place where the witnesses sign.)		
33	I declare under penalty of perjury that the principal is		
34	personally known to me, that the principal signed or		
35 36	acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no		
30 37	duress, fraud or undue influence, that I am not the person		
38	appointed as agent by this document and that I am not a		
39	provider of health care, an employee of a provider of health		
40 41	care, the operator of a [community] <i>health</i> care facility or an employee of an operator of a health care facility.		
42			
43 44	Signature: Residence Address: Print Name:		
44 45	Date:		
	****** * * A B 1 2 8 R 1 *		

1	Signature:	Residence Address:
2	Print Name:	
3	Date:	
4		
5		THE ABOVE WITNESSES MUST
6	ALSO SIGN THE FOLLO	WING DECLARATION.)
7		
8		of perjury that I am not related to
9		rriage or adoption and that to the
10		am not entitled to any part of the
11		the death of the principal under a
12	will now existing or by ope	ration of law.
13		
14	Signature:	
15		
16	Signature:	
17		
18		
19	Names:	Address:
20	Print Name:	
21	Date:	
22		
23		etain an executed copy of this
24		your agent. The power of attorney
25		py may be given to your providers
26	of health care.	
27	Sec. 7. This act becomes eff	ective upon passage and approval.

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