

LIVING WILL

TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN AND MY LAWYER:

If the time comes when I can no longer take part in decisions for my own future, let this statement stand as the testament of my wishes: If there is no reasonable expectation of my recovery from physical or mental disability, I, _____, request that I be allowed to die, and not be kept alive by artificial means or heroic measures. Death is as much a reality as birth, growth, maturity and old age - it is the one certainty. I do not fear death as much as I fear the indignity of deterioration, dependence and hopeless pain. I ask that medication be mercifully administered to me for terminal suffering, even if it hastens the moment of death.

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 to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to the Rights of Terminally Ill Act.

Dated this ____ of _____, _____.

Name

STATE OF NEBRASKA)
)ss.
COUNTY OF SEWARD)

BE IT KNOWN, that on the ____ day of _____, _____, before me personally appeared _____, above named, who is to me known to be the person described in and who executed the above Durable Power of Attorney, and acknowledged the same to be his voluntary act and deed.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and affixed my official seal, the day and year last above written.

Notary Public

POWER OF ATTORNEY FOR HEALTH CARE

I, _____, of Seward County, Nebraska, hereby appoint _____, of Seward County, Nebraska as my attorney-in-fact for health care. If she is unable or unwilling to so serve I appoint, _____ as my 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.

I direct that my attorney in fact comply with the following instructions or limitations: my attorney in fact shall have no limitations in determining medical treatment on my behalf.

I direct that my attorney-in-fact comply with the following instructions of life sustaining treatment: If I am suffering from a terminal condition or am in a persistent vegetative state, my attorney-in-fact shall have authority to withhold or withdraw life-sustaining procedures.

I direct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration: If I am suffering from a terminal condition or am in a persistent vegetative state, my attorney-in-fact shall have authority to withhold or withdraw artificially administered nutrition or hydration.

Dated _____

Signature

STATE OF NEBRASKA)
)ss.
COUNTY OF SEWARD)

On this ____ day of _____, _____, before me, a notary public in and for Seward County, personally came _____, who is to me personally known to be the identical person described in, and who executed the above Power of Attorney for Health Care, 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.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name and affixed my official seal, the day and year last above written.

Notary Public

WARNING TO PERSON EXECUTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document you should know these important facts:

1. This document gives the person you designate as your attorney in fact the power to make health care decisions for you when you are determined to be incapable. Although not necessary and neither encouraged nor discouraged, you may wish to state instructions or wishes and limit the authority of your attorney in fact;

2. Subject to the limitation stated in subdivision (d) of this document, the person you designate as your attorney in fact has a duty to act consistently with your desires as stated in this document or otherwise made known by you or, if your desires are unknown, to act in a manner consistent with your best interests. The person you designate in this document does, however, have the right to withdraw from this duty at any time;

3. You may specify that any determination that you are incapable of making health care decisions must be confirmed by a second physician;

4. The person you designate as your attorney in fact will not have the authority to consent to the withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition or hydration unless you give him or her that authority in this power of attorney for health care or in some other clear and convincing manner;

5. This power of attorney for health care should be reviewed periodically. It will continue in effect indefinitely unless you exercise your right to revoke it. You have the right to revoke this power of attorney at any time while you are competent by notifying the attorney in fact or your health care provider of the revocation orally or in writing;

6. Despite any provisions in this power of attorney for health care, you have the right to make health care decisions for yourself as long as you are not incapable of making those decisions; and

7. If there is anything in this power of attorney for health care you do not understand you should seek legal advice. This power of attorney for health care will not be valid for making health care decisions unless it is signed by two qualified witnesses who are personally known to you, or a qualified Notary Public, and who are present when you sign or acknowledge your signature.