Nebraska Power of Attorney
Health Care

POWER OF ATTORNEY FOR HEALTH CARE

I, ______________________________ (your name) name the following person as my attorney in fact for health care:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

SUCCESSOR TO POWER OF ATTORNEY FOR HEALTH CARE

If my agent (above) is unwilling or unable to act, I appoint the following person as my successor power of attorney for health care:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

By initialing the below, I acknowledge that I have read and understand each statement and the consequences of executing a power of attorney for health care.

_____ I authorize my attorney in fact for health care 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 direct that my attorney in fact for health care comply with the following instructions or limitations:

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_____ I direct that my attorney in fact for health care comply with the following instructions on life-sustaining treatment: (optional)
limitations: ______________________________

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_____ I direct that my attorney in fact for health care comply with the following instructions on artificially administered nutrition and hydration: (optional)

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______________________________ ______________________________

______ 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 for health care, 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.

______ I have read the above warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

______________________________ ______________________________

Signature of person making designation *Date*

Do not sign this form until you are in the presence of either the two witnesses or a Notary.

DECLARATION OF WITNESSES

We declare that the individual signing this power of attorney for health care is personally known to us, has signed or acknowledged his or her signature on this power of attorney for health care in our presence, and appears to be of sound mind and not under duress or undue influence. Furthermore, neither of us, nor the principal's attending physician, is the person appointed as attorney in fact for health care by this document.

Witnessed by:

______________________________ ______________________________

Signature of Witness/Date *Printed Name of Witness*

______________________________ ______________________________

Signature of Witness/Date *Printed Name of Witness*

OR

NOTARY

State of Nebraska)
) ss.
[County] of ______________)

This document was acknowledged before me on ______________________________

Date

by ______________________________

Name of Principal

______________________________ *(Seal, if any)*

Signature of Notary

My commission expires: ______________________________

Power of Attorney, DC 6:13 PSC, Rev. 03/16 §30-3408