~ Nevada ~

Durable Power of Attorney For Health Care Decisions Christian Version

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:

1. This document gives the person you designate as your agent 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.

2. 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.

3. 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 or stopping treatment which would keep you alive.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. This document revokes any prior Durable Power of Attorney for Health Care.

10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

STATE OF NEVADA
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

Written in accordance with Nevada Revised Statutes § 162A.860

DESIGNATION OF AGENT

I, _____, do hereby designate and appoint:
(Insert Your Name)

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 Attorney by appointing the person designated above to make health care decisions for me. This Durable Power of Attorney shall not be affected by my subsequent incapacity.

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 agent 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; to request review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth below ("SPECIAL PROVISIONS AND LIMITATIONS").

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, sterilizations, 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 authority, you should list them in the space below. If you do not want any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth above ("GENERAL STATEMENT OF AUTHORITY GRANTED"), 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 agent is subject to the following special provisions and limitations:

1. I request that the attached Addendum (pages 8-13) be included as a valid part of this Durable Power of Attorney for Health Care Decisions document.

2. I request, but not as a requirement, that my agent consult my clergy regarding health care decisions.

3. _____

_____

_____

[Attach additional pages, if needed]

DURATION

I understand that this Durable Power of Attorney for Health Care 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 agent will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE) I wish to have this Durable Power of Attorney end on the following date: ____/_____/_____

STATEMENT OF DESIRES

With respect to decisions to withhold or withdraw life-sustaining treatment, your agent 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 agent 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 LINE 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.

[_____] 2. 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.)

[_____] 3. 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, and sections 2 to 12, inclusive, of this act if this subparagraph is initialed.)

[_____] 4. 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 gastro-intestinal tract after all other treatment is withheld.

[_____] 5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My agent 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.

[_____] 6. As a Christian, I want my agent to make decisions in accordance with the Addendum attached to this Durable Power of Attorney for Health Care Decisions document. My general statement concerning the withholding or removal of life-sustaining treatment is described on those pages.

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

Other or Additional Statements of Desires: _____

_____

_____

[Attach additional pages, if needed]

DESIGNATION OF ALTERNATE AGENT

You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in "DESIGNATION OF AGENT" on page 2, in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated on page 2 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.

If the person designated on page 2 as my agent is unable to make health care decisions for me, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

First alternate agent

Print name: _____ Phone: (_____) _____

Address: _____

Signature: _____

Second alternate agent

Print name: _____ Phone: (_____) _____

Address: _____

Signature: _____

PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care.

WAIVER OF CONFLICT OF INTEREST

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

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.

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.

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.

You must sign and date this durable power of attorney for health care document. This durable 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.

SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

I sign my name to this Durable Power of Attorney for Health Care on ____/ _____/_____,
Date

at _____, _____.
City State

Signature: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

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

State of Nevada

County of _____ } ss.

On this _____ day of _____, in the year _____, before me,

_____ personally appeared _____
Name of notary public 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.

NOTARY SEAL

Signature of Notary Public: _____

---------- OR ----------

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 agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; or (5) an employee of an operator of a health care facility. ***At least one of the witnesses must make the additional declaration set out on page 7 of this document.]***

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 agent 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.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

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

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 am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Date: _____

Signature: _____ Date: _____

<u>COPIES</u>: You should retain an executed copy of this document and give one to your agent. The power of attorney should be available so a copy may be given to your providers of health care.

ADDENDUM TO THE STATE OF NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief that life is a gift from God and in the inherent value of human life. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my agent may consent to the withholding or withdrawal of life-sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my agent may not have a feeding tube withheld or withdrawn from me.

My agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my agent may not have a feeding tube withheld or withdrawn from me.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section above, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my agent may make health care decisions for me even if he or she knows I am pregnant. If I have checked "No" to the following, my agent may not make health care decisions for me if my agent knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ADMISSION TO NURSING HOMES

My agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my agent may only admit me for short–term stays for recuperative care or respite care.

You must sign and date this Addendum to the durable power of attorney for health care document. This durable 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.

STATEMENT OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

I have read this Addendum to the Nevada Durable Power of Attorney for Health Care Decisions – Christian Version. 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 Durable Power of Attorney for Health Care and Addendum at any time by notifying my agent, my physician, or the facility in which I am a patient or resident.

I sign my name to this Addendum to the Nevada Durable Power of Attorney for Health Care Decisions – Christian Version on

_____ day of _____, _____ at _____, _____
Month Year City State

Signature: _____ Print name: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

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

State of Nevada

County of _____ } ss.

On this _____ day of _____, in the year _____, before me,

_____ personally appeared _____
Name of notary public 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.

NOTARY SEAL

Signature of Notary Public: _____

---------- OR ----------

STATEMENT OF WITNESSES

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 Addendum 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 agent 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.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents.)

STATEMENT OF AGENT AND ALTERNATE AGENTS

I understand that _____ has designated me to be his or her agent or alternate
Name of principal
agent if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____

Address: _____

First alternate agent's signature: _____

Address: _____

Second alternate agent's signature: _____

Address: _____

CLERGY
Optional

The declarant has requested that the agent consult me, as the declarant's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

Clergy's signature: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Durable Power of Attorney for Health Care Decisions – Christian Version to:

_____

_____

_____

_____

_____

_____