Power of Attorney for Healthcare

I appoint _____ whose address is _____

_____, and whose telephone number is

_____, as my agent for healthcare. My agent has the right to make healthcare decisions for me if I cannot make my own healthcare decisions.

My agent is to act for me in making healthcare decisions, including decisions about whether to provide or to continue life-sustaining medical treatment and/or the giving of food and water to me artificially.

I appoint _____, whose address is _____

_____, and whose telephone number is

_____, as my successor agent for healthcare if my agent named above is unwilling or unable to serve.

I UNDERSTAND THAT THIS DOCUMENT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I CANNOT MAKE SUCH DECISIONS. I UNDERSTAND THAT I CAN CANCEL OR REVOKE THIS POWER OF ATTORNEY FOR HEALTHCARE AT ANY TIME BY NOTIFYING MY AGENT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT.

I have signed this Power of Attorney for Healthcare on the _____ day of _____, 20_____.

_____
Signature of Person Appointing the Agent

State of Nebraska)
) ss.
County of _____)

On this _____ day of _____, 20_____, this Power of Attorney for Healthcare was signed and acknowledged before me by _____ _____ as his or her voluntary act. I declare that he or she appears in sound mind and not under duress or undue influence, and that I am not the agent for healthcare or the successor agent appointed in this power of attorney for healthcare.

Patient Information Label

_____
Signature of Notary Public