

Living Will Sample Nevada (aka "Advanced Medical Directive")

[Online Living Will Form \\$8.99 \(free trial\)--click here](#)

ADVANCE MEDICAL DIRECTIVE AND POWER OF ATTORNEY FOR HEALTH CARE GIVEN BY JAMES ROBERT HEDGES

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 ATTORNEY-IN-FACT 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 TREATMENT 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.

* * * * *

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me: **Sara Jane Hedges** whose residence is 1212 Holiday Drive, Louisville, KY.

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including those forms of health care necessary to keep me alive. Furthermore, the authority I give my agent shall include decisions to provide, withhold, or withdraw artificial nutrition. The power of my agent granted herein shall not be affected by my subsequent incapacity.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and documented in my medical records that I am either terminally ill **or** that I am in a state of persistent unconsciousness with no reasonable expectation of recovery.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care and any instructions I give in Part 2 of this form. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration, I express to my physician, family and friends my intent.

(6) END-OF-LIFE DECISIONS: In cases where both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and document in my medical records that I am either terminally ill or that I am in a state of persistent unconsciousness with no reasonable expectation of recovery, I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have stated below. The word "Withhold" shall be used to mean both withholding the treatment if it has not yet been given and withdrawing the treatment if it is currently being administered.

* Artificially supplied nutrition and hydration (including tube feeding or food and water)	Withhold
* Surgery or other invasive procedures (i.e., those where medical instruments must enter the body)	Withhold
* Heart-lung resuscitation (CPR)	Withhold
* Antibiotics	Do NOT Withhold
* Kidney or Renal dialysis	Withhold
* Mechanical ventilator (respirator)	Withhold
* Chemotherapy and other radiation therapy	Withhold
* All other "life sustaining" medical procedures that are merely intended to keep me alive without reasonable hope of improving my condition	Withhold

I hereby acknowledge the above choices:

JAMES ROBERT HEDGES

Declarant / Principal

(7) RELIEF FROM PAIN: I direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

(8) HIPAA Privacy Authorization. I hereby authorize my Agent to execute any form authorization for use or disclosure of my Protected Health Information relating to past, present or future medical records required by the Health Insurance Portability and Accountability Act ("HIPAA"). My Agent is authorized to execute a HIPAA form authorization for release of my medical records in favor of any health provider or other party that the Agent deems appropriate.

**PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)**

(10) ORGAN DONATION: Upon my death, I wish to donate any and all of my organs, tissues, or other bodily parts for use in transplant to another human being. I authorize my health care agent to give consent to the medical organization of his choosing for donation of my aforementioned body parts.

**PART 4
PRIMARY PHYSICIAN
(OPTIONAL)**

(11) DESIGNATION OF PHYSICIAN: I designate the following physician as my primary physician: John Paul Jones, MD.

* * * * *

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) DURABILITY OF HEALTH CARE AGENT'S POWERS: This Health Care Power of Attorney is a durable power of attorney and the authority of my agent shall not terminate if I become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive. If I have also executed a durable financial power of attorney, this document is not meant to override that document. My health care agent's powers only extend to health care decisions as outlined in this document.

(14) DEFINITIONS:

"Artificially Provided Nutrition and Hydration" means feeding a patient through a means that is not natural such as (1) intravenously (i.e., inserting a needle directly into a patient's veins through which food or water would be forced into the patient's blood stream) or (2) a feeding tube inserted in the nose or mouth through which food or water would be forced into an individual's stomach. Assisted feeding, such as by a spoon or bottle, where the patient actively participates in the feeding process by chewing or swallowing is not considered "artificially provided nutrition and hydration".

"Persistently Unconscious" means a condition that, to a reasonable degree of medical certainty: (a) will last permanently without improvement, (b) one in which cognitive thought, purposeful action, and awareness of self and environment are absent, and (c) which has existed for a period of time sufficient, in accordance with applicable medical standards, to make a diagnosis called for in parts (a) and (b) hereof.

"Terminally Ill" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, to a reasonable degree of medical certainty, result in death within a relatively short time.

"Life-Sustaining Treatment" means any medical treatment, procedure, or intervention that,

in the judgment of the attending physician, when applied to the patient, would serve only to prolong the dying process where the patient has a terminal illness or injury, or would serve only to maintain the patient in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, surgery, chemotherapy, CPR, dialysis, use of mechanical respirators, blood transfusions, and the administration of all drugs and antibiotics (except those intended to ease pain).

(Note: This page is **not** to be attached to your Health Care Directive.)

INSTRUCTIONS REGARDING EXECUTION OF YOUR HEALTH CARE DIRECTIVE AND MEDICAL POWER OF ATTORNEY

- A. Please remember to fill in your social security number below your name on the signature page.
- B. **Please note that the principal's signature is required on pages 3 and 5 of this document.**
- C. We recommend that you execute two originals of your Health Care Directive. Give the first original to the Health Care Agent you named and you retain the second original in your home in place known to family members. If you currently under medical care for a serious medical condition, we also suggest you execute a third original and give it to your primary physician.
- D. **Witnesses.** We have written this health care directive to be valid in all 49 states (and the District of Columbia) whose laws allow for this type of document. There are varying rules among the states regarding what types of persons cannot witness a health care directive. As such, we have included with our form all the prohibitions against witness from the across the country making the list somewhat length. The following persons cannot act as a witness to a health care directive:
1. A health care provider for Declarant,
 2. An employee of a health care provider for Declarant,
 3. The operator or employee of a community or long-term care facility,
 4. Patient in a health care facility in which declarant is a patient,
 5. Individual with a claim against Declarant's estate,
 6. Individual who has a financial responsibility for Declarant's medical care, and
 7. Individual related by blood, marriage, or adoption to Declarant.
- Also, the health care agent should not be one of the witnesses to this document.** The two witnesses need to be physically present when you sign the health care directive and attest to the fact that they saw you sign the document. If you have the document notarized, the witnesses will need to be with you in front of the notary.
- E. Where do I get a notary? Your local bank is the best place to find a notary. If you cannot find a notary at your bank, please consult your local Yellow Pages which has them listed under "notaries public".
- F. Notice: This form is not intended for use in the State of Wisconsin.
- G. What if I decide to make changes to my document? We will keep your responses to the online questionnaire in our database **for 60 days after the date of purchase**. During this time, you may go to the User Administration section of our site to call up your form questionnaire and make changes—the URL is <https://www.medlawplus.com/user/>. You shall need your "user name" and "password" to re-enter the system. Once in the User Administration area, click on the text link to your form questionnaire which is located on the upper-left of the page. Make the desired changes to your responses in the questionnaire and submit to create a revised document. If you have problems calling up your old data, email us at administrator@medlawplus.com. We do our best to give a prompt response to all inquiries, usually within a few hours. NOTE: Upon registration, our system emailed to you our record of your "user name" and "password".

DISCLAIMER

The above is provided for informational purposes only and is NOT to be relied upon as legal advice. This service is not a substitute for the advice of an attorney and we encourage users to have all documents created on our site reviewed by an attorney. No attorney-client relationship is established by use of our online legal forms system and the user is not to rely upon any information found anywhere on our site. **THESE FORMS ARE SOLD ON AN "AS IS" BASIS WITH NO WARRANTIES OR GUARANTIES.** If you wish personal assistance in deciding whether the document found on our site is right for you or desire representations and warranties upon the legality of the document you are purchasing in the jurisdiction you will be using it, contact an attorney licensed to practice law in your state.