

## Nebraska Power of Attorney for Health Care

I, \_\_\_\_\_, the principal, appoint \_\_\_\_\_, whose address is \_\_\_\_\_, and whose telephone number is \_\_\_\_\_, as my **attorney-in-fact** for Health Care.

I appoint \_\_\_\_\_, whose address is \_\_\_\_\_, and whose telephone number is \_\_\_\_\_, as my **successor 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 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:

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I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment: \_\_\_\_\_

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I direct that my attorney-in-fact comply with the following instructions on artificially administered nutrition and hydration:

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I request that a second physician confirm my incapacity. \_\_\_\_\_ YES \_\_\_\_\_ NO

**I have read this Power of Attorney for Health Care and have discussed/ will discuss my wishes with my Power of Attorney. 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, my physician, or the facility in which I am a patient or resident.**

Signature \_\_\_\_\_ Address \_\_\_\_\_  
Printed Name \_\_\_\_\_  
Date \_\_\_\_\_

# Nebraska Power of Attorney for Health Care (Cont'd)

## Declaration of Witnesses

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Power of Attorney for Health Care in our presence, and that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us, nor the principal's attending Physician, Nurse Practitioner, or Physician's Assistant is the person appointed as attorney-in-fact.

Witness Signature \_\_\_\_\_  
Print Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_

Witness Signature \_\_\_\_\_  
Print Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_

**OR**

State of Nebraska            )  
                                      )SS.  
County of \_\_\_\_\_    )

On this \_\_\_\_ day of \_\_\_\_\_ 20\_\_, before me, \_\_\_\_\_,  
a notary public in and for \_\_\_\_\_ County, \_\_\_\_\_  
voluntarily signed this document in my presence.

Witness my hand and notarial seal at \_\_\_\_\_ in such county the day and year last written.

Notary Signature \_\_\_\_\_ Seal →