

NEVADA

Advance Directive

Planning for Important Health Care Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. Nevada maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at www.livingwilllockbox.com.
6. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Nevada Advance Directive

This packet contains a legal document, a **Nevada Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III. You must complete Part IV if you meet the prerequisites.

Part I is the **Nevada Durable Power of Attorney for Health Care Decisions**, which lets you name someone, called your agent, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself. The power of attorney for health care decisions is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life. Part I also allows you to express your desires regarding your health care and other advance planning decisions, including your desires regarding life-sustaining treatments, in order to help guide your agent. Part I goes into effect when your doctor determines in writing that you are no longer able to make or communicate your health care decisions.

Part II is a **Nevada Declaration**, which is your state's living will. Part II lets you state your wishes regarding the withholding and withdrawing of life-sustaining treatments, including the artificial administration of nutrition and hydration, in the event that you can no longer make your own health care decisions and you are terminally ill. The declaration in Part II becomes effective when—and is only effective when—your attending physician determines that (1) you are incapable of making decisions about the use of life-sustaining treatment and (2) you have a terminal condition. Because Part II is limited in this way and Part I allows you to express the same decisions, if you plan to complete Part I, you may wish to leave Part II blank and record your advance planning wishes in Part I only.

Part III contains the signature and witnessing provisions so that your document will be effective.

Following the advance directive is an **Organ Donation Form**.

Part IV contains the certification of competency that must be filled out by a physician, psychologist, or psychiatrist if you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care at the time of completing your advance directive.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult who is at least 18 years of age.

Instructions for Completing Your Nevada Advance Directive

How do I make my Nevada Advance Directive legal?

Nevada requires that you execute your form using the Nevada statutory language, which is reflected in the forms below.

If you fill out Part I, you can make your advance directive legal in one of two ways.

1. Sign your document in the presence of two witnesses and use the Nevada statutory language. These witnesses cannot be:

- the person you name as your agent,
- a health care provider,
- an employee of a health care provider,
- an operator of a health care facility, or
- an employee or an operator of a health care facility.

At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or by operation of law.

Signing your document in this way will also make Part II legal.

OR

2. Have your signature witnessed by a notary public and use the Nevada statutory language. Having your signature notarized will only make Part I legal (*i.e.*, Part II needs an additional witness besides the notary).

If you fill out Part II, you must sign your form in front of two witnesses and use the Nevada statutory language.

Regardless of whether you fill out Part I or Part II, if you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care, you must obtain a certification of competency filled out by a physician, psychologist, or psychiatrist at the time you complete these documents.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

Unless he or she is your spouse, legal guardian, or next of kin, the person you appoint as your agent **cannot** be:

- your health care provider,
- an employee of your health care provider,
- an operator of a health care facility, or
- an employee of a health care facility.

You can appoint two or more persons to act as co-agents. Unless you provide otherwise, each co-agent will be able to exercise authority independently. You also may appoint one or more successor agents who step in if the person you name as agent is unable, unwilling or unavailable to act for you.

Should I add personal instructions to my Nevada Advance Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your advance directive at any time in any manner that expresses your intent.

You may revoke the appointment of your agent (Part I) at any time by notifying your agent or your treating physician, hospitals, or other health care provider orally or in writing.

Your durable power of attorney (Part I) is automatically revoked if:

- you execute a new durable power of attorney, or
- you appoint your spouse as your agent and your marriage ends (unless you state otherwise under Part I).

If you wish to set an expiration date for your durable power of attorney (Part I), you may do so on page 4, section 5. If you do not set an expiration date, your durable power of attorney remains valid until it is revoked.

Revocation of your declaration (Part II) is effective when you notify your attending physician.

What other important facts should I know?

A direction to withhold or withdraw life-sustaining treatment from a pregnant patient is not effective if it is probable that the fetus would survive to the point of live birth with continued life-sustaining treatment.

Your agent does not have the power to authorize any of the following:

- Abortion
- Sterilization
- Commitment or placement in a facility for treatment of mental illness
- Convulsive treatment
- Psychosurgery
- Aversive intervention (punishment meant to encourage or discourage behavior)
- Experimental, biomedical, or behavioral treatment, or participation in any medical, biomedical, or behavioral research program
- Any other treatment for which you, in your Durable Power of Attorney for Health Care (Part I), state that your agent may not consent.

Part I. Nevada Durable Power of Attorney For Health Care Decisions

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 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

STATUTORY
WARNING

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.

STATUTORY
WARNING
(CONTINUED)

PRINT YOUR
NAME

PRINT THE
NAME, ADDRESS
AND PHONE
NUMBER OF YOUR
AGENT

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____, do hereby designate and appoint:
(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 you designate is 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 a health care facility.

2. 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 power of attorney shall not be affected by my subsequent incapacity.

3. 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; to execute on my behalf any releases or other documents that may be required to obtain medical care and/or 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 in paragraph 4 or 6.

4. SPECIAL PROVISION 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, sterilization, 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 write any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, 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:

5. DURATION.

I understand that this power of attorney 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 attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

I wish to have this power of attorney end on the following date:

ADD ADDITIONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE SCOPE OF YOUR AGENT'S AUTHORITY

PRINT THE EXPIRATION DATE (OPTIONAL)

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6. 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.

Initial _____

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.

Initial _____

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.

Initial _____

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.

Initial _____

5. I do **not** desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact 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.

Initial _____

(If you wish to change your answer, you may draw an "X" through the answer you do not want, circle the answer you prefer, and initial the changes)

INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES (OPTIONAL)

ANY INSTRUCTIONS ON THE USE OF LIFE-SUSTAINING OR PROLONGING TREATMENTS SHOULD BE CONSISTENT WITH INSTRUCTIONS PROVIDED IN YOUR NEVADA DECLARATION (PART II), IF ANY

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7. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternate agent but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 3 in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1, is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 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:

A. First Alternate Agent

Name: _____

Address: _____

Telephone Number: _____

B. Second Alternate Agent

Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.

9. 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.

PRINT THE NAME,
ADDRESS AND
PHONE NUMBER OF
YOUR FIRST
ALTERNATE AGENT

PRINT THE NAME,
ADDRESS AND
PHONE NUMBER OF
YOUR SECOND
ALTERNATE AGENT

10. 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. The durable power of attorney for health care must be construed and interpreted in accordance with the laws of the State of Nevada.

11. 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.

12. 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.

This section is not required, and you may cross it out if you desire.

Part II: Declaration Relating to the Use of Life-Sustaining Treatment

If I should lapse into an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time (a terminal condition) and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Nevada Uniform Act on the Rights of the Terminally Ill, to:

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available life-sustaining treatment or other medical interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

Any questions regarding how to interpret or apply my declaration shall be resolved by my agent appointed under a durable power of attorney for health care (Part I), if I have appointed one.

I further direct that:

(Attach additional pages if needed)

PART II ONLY APPLIES TO WITHHOLDING OR WITHDRAWING OF LIFE-SUSTAINING TREATMENTS IF YOU ARE TERMINALLY ILL

BECAUSE PART II IS LIMITED IN THIS WAY, IF YOU PLAN TO COMPLETE PART I, YOU MAY WISH TO LEAVE PART II BLANK AND RECORD YOUR ADVANCE PLANNING WISHES IN PART I.

INITIAL ONLY ONE

ADD ADDITIONAL INSTRUCTIONS, IF ANY, IN THE EVENT YOU HAVE A TERMINAL CONDITION

ATTACH ADDITIONAL PAGES IF NEEDED

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PART III: EXECUTION

Nevada requires that you execute your form using the Nevada statutory language, which is reflected in the forms below.

If you fill out Part II, you must sign your form in front of two witnesses and use the Nevada statutory language.

If you fill out Part I, you can make your advance directive legal in one of two ways.

1. Sign your document in the presence of two witnesses and use the Nevada statutory language. These witnesses cannot be:

- the person you name as your agent,
- a health care provider,
- an employee of a health care provider,
- an operator of a health care facility, or
- an employee or an operator of a health care facility.

At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or by operation of law.

Signing your document in this way will also make Part II legal.

OR

2. Have your signature witnessed by a notary public and use the Nevada statutory language. Having your signature notarized will only make Part I legal (i.e., Part II needs an additional witness besides the notary).

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.

IF YOU FILLED OUT PART II, YOU MUST HAVE YOUR DOCUMENT WITNESSED

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

REQUIRED STATEMENT BY ONE OF THE ABOVE WITNESSES IF YOU FILLED OUT PART I

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Alternative No. 1: Sign before witnesses.

I sign my name to this Durable Power of Attorney for Health Care on

_____ at _____, _____.
(date) (city) (state)

(signature)

(print name)

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, and 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 or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: _____

Date: _____

Witness 2:

Signature: _____ Residence Address: _____

Print Name: _____

Date: _____

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that 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: _____ Residence Address: _____

Print Name: _____

Date: _____

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SIGNING BEFORE A NOTARY PUBLIC IS ONLY AN OPTION IF YOU DID NOT FILL OUT PART II

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

Alternative No. 2: Sign before a notary public.

I sign my name to this Durable Power of Attorney for Health Care on

_____ at _____, _____.
(date) (city) (state)

(signature)

(print name)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

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)

ASK YOUR
TREATING
PHYSICIAN,
PSYCHOLOGIST, OR
PSYCHIATRIST TO
FILL THIS OUT

PRINT YOUR NAME
HERE

PRINT YOUR NAME
HERE

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PART IV: CERTIFICATION OF COMPETANCY

If you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care, Nevada requires that you include a certification of competency from a physician, psychologist, or psychiatrist along with your power of attorney:

The undersigned treating (physician/psychologist/psychiatrist) of _____ states as follows:

1. That I am a licensed (physician/psychologist/psychiatrist) practicing in the State of _____, and I have been a licensed (physician/psychologist/psychiatrist) for ____ years. My present address is _____.

2. That I have examined _____ and have concluded as a result of that examination that the he/she is mentally competent to understand the nature of the Durable Power of Attorney for Health Care proceedings and the delegation of authority to an agent.

(Signature of certifying physician/psychologist/psychiatrist) (Date)

(Name of certifying physician/psychologist/psychiatrist)

*Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

NEVADA ORGAN DONATION FORM – PAGE 1 OF 1

ORGAN DONATION
(OPTIONAL)

INITIAL THE
OPTION THAT
REFLECTS YOUR
WISHES

ADD NAME OR
INSTITUTION (IF
ANY)

PRINT YOUR NAME,
SIGN, AND DATE
THE DOCUMENT

YOUR WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES

AT LEAST ONE
WITNESS MUST BE
A DISINTERESTED
PARTY

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Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Nevada law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution: _____

_____ Pursuant to Nevada law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____ Date _____

Address _____

*Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Nevada Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. Nevada maintains an Advance Directive Registry. By filing your advance directive with the registry, your health care provider and loved ones may be able to find a copy of your directive in the event you are unable to provide one. You can read more about the registry, including instructions on how to file your advance directive, at www.livingwilllockbox.com.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
7. Remember, you can always revoke your Nevada document.
8. Be aware that your Nevada document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Nevada law authorizes the use of a Physician Order for Life–Sustaining Treatment (POLST) form, which is designed to help health care providers honor your wishes regarding CPR and other health care decisions. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**