State: Nevada

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a description of Nevada law concerning advance directives (NRS 449.540 to 449.690, inclusive, and sections 2 to 12, inclusive of Chapter 258, Statutes of Nevada 1991):

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is generally a written statement, which individuals complete in advance of serious illness, about how they want medical decisions made. The two most common forms of advance directive are:

- a "Living Will," or "Declaration";
- a "Durable Power of Attorney for Health Care."

An advance directive allows individuals to state their choices for health care or to name someone to make those choices for them, if they become unable to make decisions about their medical treatment. In short, an advance directive can enable individuals to make decisions about their future medical treatment. They can say "yes" to treatment they want, or say "no" to treatment they do not want.

WHAT IS A LIVING WILL OR DECLARATION?

A Living Will or Declaration generally states the kind of medical care individuals want (or do not want) if they become unable to make their own decisions. It is called a "Living Will" because it takes effect while they are still living.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

A "Durable Power of Attorney for Health Care" is a signed, dated, and witnessed paper naming another person, such as a husband, wife, daughter, son, or close friend as an "agent" or "proxy" to make medical decisions for an individual who should become unable to make such decisions. The power of attorney includes instructions about any treatment the individual may want or wish to avoid, such as surgery or artificial feeding.

IS IT REQUIRED TO WRITE AN ADVANCE DIRECTIVE UNDER THE LAW?

No. It is entirely up to the individual.

CAN AN INDIVIDUAL CHANGE HIS/HER MIND AFTER A LIVING WILL OR HEALTH CARE POWER OF ATTORNEY IS WRITTEN?

Yes. Individuals may change or cancel these documents at any time in accordance with state law. Any change or cancellation should be written, signed, and dated in accordance with state law, and copies should be given to the family doctor, or to others to whom the individual may have given copies of the original.

If an individual wishes to cancel an advance directive while in the hospital, the individual should notify his/her doctor, family, and others who may need to know.

Even without a change in writing, wishes stated in person directly to an individual's doctor generally carry more weight than a living will or durable power of attorney, as long as the individual can decide and can communicate his/her wishes. The individuals must be sure to state their wishes clearly and be sure that they are understood.

This is a form of a "Declaration," provided for under Nevada Statutes:

DECLARATION

If I should have 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, and I am no longer able to make decisions regarding my medical treatment, I direct may attending physician, pursuant to NRS 449.540 to 449.690, inclusive, and section 2 to 12, inclusive, of this act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include this statement, you must INITIAL the statement in the box provided. (If the statement reflects your desires, initial the box next to the statement.)

I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastrointestinal tract if such a withholding or withdrawal would result in my death by starvation or dehydration. [_____]

Signed this _____ day of _____, 19____.

Signature: _____
Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____
Address: _____

Witness: _____
Address: _____

This is the form of a "Durable Power of Attorney" for health care decisions provided for under Nevada Statutes:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSONS 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.

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1. DESIGNATION OF HEALTH CARE AGENT

I, _____ (insert your name) do hereby designate and appoint:

Name: _____

Address: _____

Telephone: _____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the persons you wish to designate as your attorney-in-fact 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 follow-ing may be designated as your attorney-in-fact: 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.)

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 attorney-in-fact 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 physical or mental condition, subject only to the limitations and special providers, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact 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 attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact 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 attorney-in-fact 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 by attorney-in-fact 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 power of attorney end on the following date:

_____

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact 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 attorney-in-fact 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 box 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 449.540 to 449.690, inclusive, and sections 2 to 12, inclusive, of chapter 258, Statutes of Nevada 1991, if this subparagraph is initialed.) [_____]

3. If I have an incurable or terminal condition or illness and no reasonable hope of of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.540 to 449.690, inclusive, and sections 2 to 12, inclusive, of chapter 258, Statutes of Nevada 1991, if this subparagraph is initialed.) [_____]

4. 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. [_____]

(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: _____
_____
_____
_____

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact, but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such person to serve in the order listed below:

A. First Alternative Attorney-in-Fact
Name: _____
Address: _____
Telephone: _____

B. Second Alternative Attorney-in-Fact
Name: _____
Address: _____
Telephone: _____

8. PRIOR DESIGNATIONS REVOKED

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

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for Health Care on _____(date) at _____(city), _____(state).

_____
Signature

(This 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.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

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

State of Nevada)
) ss:
County of_____)

On this _____ day of _____, in the year _____, before me, _____ (here insert name of notary public) personally appeared _____ (here insert 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

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 attorney-in-fact; 2) a provider of health care; 3) an employee of a provider of health care; 4) the operator of a health care facility; 5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

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 attorney-in-fact 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.

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

(At least one of the above witnesses 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: _____
Signature: _____

Names: _____
Print Names: _____
Address: _____
Date: _____

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be avail-able so a copy may be given to your providers of health care.

Under section 11 of Chapter 258, Nevada Statutes 1991, a health care provider is allowed to transfer care of a patient to another provider if the first provider objects on the basis of conscience to implementation of an advance directive.