Nebraska Power of Attorney
Health Care

POWER OF ATTORNEY FOR HEALTH CARE

I, ______________________________ (your name) name the following person as my attorney in fact for health care:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

SUCCESSOR TO POWER OF ATTORNEY FOR HEALTH CARE

If my agent (above) is unwilling or unable to act, I appoint the following person as my successor power of attorney for health care:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

By initialing the below, I acknowledge that I have read and understand each statement and the consequences of executing a power of attorney for health care.

_____ I authorize my attorney in fact for health care 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 direct that my attorney in fact for health care comply with the following instructions or limitations:

____

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_____ I direct that my attorney in fact for health care comply with the following instructions on life-sustaining treatment: (optional)
limitations: ______________________________

____

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_____ I direct that my attorney in fact for health care comply with the following instructions on artificially administered nutrition and hydration: (optional)

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_____ I have read this power of attorney for health care. 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 for health care, my physician, or the facility in which I am a patient or resident. I also understand that I can require in this power of attorney for health care that the fact of my incapacity in the future be confirmed by a second physician.

_____ I have read the above warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

_______________________________________ _____________________

Signature of person making designation ***Date***

Do not sign this form until you are in the presence of either the two witnesses or a Notary.

DECLARATION OF WITNESSES

We declare that the individual signing this power of attorney for health care is personally known to us, has signed or acknowledged his or her signature on this power of attorney for health care in our presence, and appears to be of sound mind and not under duress or undue influence. Furthermore, neither of us, nor the principal's attending physician, is the person appointed as attorney in fact for health care by this document.

Witnessed by:

_______________________________________ _____________________________

Signature of Witness/Date ***Printed Name of Witness***

_______________________________________ _____________________________

Signature of Witness/Date ***Printed Name of Witness***

OR

NOTARY

State of Nebraska)
) ss.
[County] of ________________)

This document was acknowledged before me on ____________________________________

Date

by ______________________________________

Name of Principal

______________________________________ ***(Seal, if any)***

Signature of Notary

My commission expires: ______________________

Power of Attorney, DC 6:13 PSC, Rev. 03/16 §30-3408

Nebraska Living Will Declaration

If I should lapse into a persistent vegetative state or 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 my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Other directions: ______________________________

____

____

____

Signed this ____________ day of ____________________

Signature ______________________________

Address: ______________________________

____

The declarant voluntarily signed this writing in my presence.

Witness ______________________________

Address: ______________________________

____

Witness ______________________________

Address: ______________________________

____

OR

The declarant voluntarily signed this writing in my presence.

Notary Public ______________________________

Source: § 20-404 Neb Rev Stat

Made Fillable by eForms

EMSOA
EMERGENCY MEDICAL SERVICES
OVERSIGHT AUTHORITY

555 South 70th Street
Lincoln, NE 68510

1600 South 48th Street
Lincoln, NE 68506

PHYSICIAN'S DO NOT RESUSCITATE (DNR) ORDER FOR THE MEDICALLY ILL

I, ______________________________ , have been diagnosed as having a medical illness. I have discussed both the prognosis of this illness and the treatment options with my physician and request that in the event of my cardiopulmonary arrest, cardiopulmonary resuscitation and/or mechanical ventilations not be initiated.

I give permission for this information to be given to Emergency Medical Service and Mobile Health Care personnel, physicians, nurses, or other health care personnel as necessary to carry out these wishes. I understand that this order is valid from this point forward until rescinded by either myself or my designated Durable Power of Attorney for Health Care, and further agree that a copy of this form is as valid as the original. Incomplete forms may be returned as being invalid.

☐ **DO NOT INTUBATE** I understand that **DO NOT INTUBATE** means that in the event that my breathing is inadequate I do not wish a tube placed in my airway to maintain my respirations artificially.

☐ **DO NOT RESUSCITATE (DNR**) I understand that DNR means that if my heart stops beating, or is inadequate, or that if I stop breathing or my breathing is inadequate, that no artificial resuscitation will be initiated or continued. I understand that I will continue to receive supportive medical care as deemed appropriate by health care personnel, though cardiopulmonary resuscitation will not take place.

____ ______________________________

Patient, or Next of Kin Signature or Guardian of Person or Durable Power of Attorney for Health Care (Attach Appointment form). | Date

____ ______________________________

Patient Address (Including facility name if applicable) | Witness

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I certify that I have discussed his or her medical illness, treatment and prognosis with the patient and that the entry of this DNR order is appropriate for:

______________________________ ______________________________

Patient Name | Date of Birth

______________________________ ______________________________ Date:__/__/__

Printed Physician Name | Physician Signature

____ Date: __/__/__

Agency Completing Form and Signature of Agency Representative (required if "By Telephone Order box below is checked)

☐ By telephone order, the patient's attending physician referenced above was consulted regarding the DNR status, however, was unavailable to personally appear to provide an original signature. The agency representative above verifies the consultation and authorization of the physician as indicated.

Copy Distribution:

☐ *Patient File ☐ Home Health/Hospice Agency

☐ Attending Physician ☐ Patient's Home (if applicable)

*Original DNR form must be kept in patient's primary medical file.

***KEEP IN PROMINENT PLACE**

DNR ORDER

eForms