Nevada Revised Statutes § 162A.870
Power of attorney for adult with dementia: Form.

1. The form of a power of attorney for health care for an adult with any form of dementia may be substantially in the following form, and must be witnessed or executed in the same manner as the following form:

DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

My name is..... (insert your name) and my address is..... (insert your address). I would like to designate..... (insert the name of the person you wish to designate as your agent for health care decisions for you) as my agent for health care decisions for me if I am sick or hurt and need to see a doctor or go to the hospital. I understand what this means.

If I am sick or hurt, my agent should take me to the doctor. If my agent is not with me when I become sick or hurt, please contact my agent and ask him or her to come to the doctor's office. I would like the doctor to speak with my agent and, if I have the capacity to understand, me about my sickness or injury and whether I need any medicine or other treatment. After we speak with the doctor, if I have the capacity to understand, I would like my agent to speak with me about the care or treatment. When we have made decisions about the care or treatment, my agent will tell the doctor about our decisions and sign any necessary papers.

If I am very sick or hurt, I may need to go to the hospital. I would like my agent to help me decide if I need to go to the hospital. If I go to the hospital, I would like the people who work at the hospital to try very hard to care for me. If I am able to communicate, I would like the doctor at the hospital to speak with me and my agent about what care or treatment I should receive, even if I am unable to understand what is being said about me. After we speak with the doctor, I would like my agent to help me decide what care or treatment I should receive. Once we decide, my agent will sign any necessary paperwork. If I am unable to communicate because of my illness or injury, I would like my agent to make decisions about my care or treatment based on what he or she thinks I would do and what is best for me.

I would like my agent to help me decide if I need to see a dentist and help me make decisions about what care or treatment I should receive from the dentist. Once we decide, my agent will sign any necessary paperwork.

I would also like my agent to be able to see and have copies of all my medical records. If my agent requests to see or have copies of my medical records, please allow him or her to see or have copies of the records.

I understand that my agent cannot make me receive any care or treatment that I do not want. I also understand that I can take away this power from my agent at any time, either by telling my agent that he or she is no longer my agent or by putting it in writing.

If my agent is unable to make health care decisions for me, then I designate..... (insert the name of another person you wish to designate as your alternative agent to make health care decisions for you) as my agent to make health care decisions for me as authorized in this document.

(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)

AGENT SIGNATURE

As agent for..... (insert name of principal), I agree that a physician, health care facility or other provider of health care, acting in good faith, may rely on this power of attorney for health care and the signatures herein, and I understand that pursuant to NRS 162A.815, a physician, health care facility or other provider of health care that in good faith accepts an acknowledged power of attorney for health care is not subject to civil or criminal liability or discipline for unprofessional conduct for giving effect to a declaration contained within the power of attorney for health care or for following the direction of an agent named in the power of attorney for health care.

I also agree that:

1. I have a duty to act in a manner consistent with the desires of..... (insert name of principal) as stated in this document or otherwise made known by..... (insert name of principal), or if his or her desires are unknown, to act in his or her best interest.

2. If..... (insert name of principal) revokes this power of attorney at any time, either verbally or in writing, I have a duty to inform any persons who may rely on this document, including, without limitation, treating physicians, hospital staff or other providers of health care, that I no longer have the authorities described in this document.

3. The provisions of NRS 162A.840 prohibit me from being named as an agent to make health care decisions in this document if I am a provider of health care, an employee of the principal's provider of health care or an operator or employee of a health care facility caring for the principal, unless I am the spouse, legal guardian or next of kin of the principal.

4. The provisions of NRS 162A.850 prohibit me from consenting to the following types of care or treatments on behalf of the principal, including, without limitation:

(a) Commitment or placement of the principal in a facility for treatment of mental illness;

(b) Convulsive treatment;

(c) Psychosurgery;

(d) Sterilization;

(e) Abortion;

(f) Aversive intervention, as it is defined in NRS 449A.203;

(g) Experimental medical, biomedical or behavioral treatment, or participation in any medical, biomedical or behavioral research program; or

(h) Any other care or treatment to which the principal prohibits the agent from consenting in this document.

5. End-of-life decisions must be made according to the wishes of..... (insert name of principal), as designated in the attached addendum. If his or her wishes are not known, such decisions must be made in consultation with the principal's treating physicians.

Signature: ..... Residence Address:

Print Name:

.....

Date:

.....

Relationship to principal:

.....

Length of relationship to principal:

.....

(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 YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGMENT
OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the 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.

NOTARY
SEAL .....

(Signature)

STATEMENT OF WITNESSES

(If you choose to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. The following people cannot be used as a witness: (1) a person you designate as the agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; or (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 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 health care facility or an employee of an operator of a health care facility.

Signature: ..... Residence Address:
Print Name:
.....
Date:
.....

Signature: ..... Residence Address:
Print Name:
.....
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 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: .....

Signature: .....

Names: ..... Address:

Print Name:

.....

Date:

.....

COPIES: 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.

2. The form for end-of-life decisions of a power of attorney for health care for an adult with any form of dementia may be substantially in the following form, and must be witnessed or executed in the same manner as the following form:

END-OF-LIFE DECISIONS ADDENDUM STATEMENT OF DESIRES

(You can, but are not required to, state what you want to happen if you get very sick and are not likely to get well. You do not have to complete this form, but if you do, your agent must do as you ask if you cannot speak for yourself.)

..... (Insert name of agent) might have to decide, if you get very sick, whether to continue with your medicine or to stop your medicine, even if it means you might not live, ... (Insert name of agent) will talk to you to find out what you want to do, and will follow your wishes.

If you are not able to talk to..... (insert name of agent), you can help him or her make these decisions for you by letting your agent know what you want.

Here are your choices. Please circle yes or no to each of the following statements and sign your name below:

1. I want to take all the medicine and receive any treatment I can to keep me alive regardless of how the medicine or treatment makes me feel. YES NO

2. I do not want to take medicine or receive treatment if my doctors think that the medicine or treatment will not help me. YES NO

3. I do not want to take medicine or receive treatment if I am very sick and suffering and the medicine or treatment will not help me get better. YES NO

4. I want to get food and water even if I do not want to take medicine or receive treatment.
YES NO

(YOU MUST DATE AND SIGN THIS END-OF-LIFE DECISIONS ADDENDUM)

I sign my name to this End-of-Life Decisions Addendum on ..... (date) at ..... (city), ... (state)

.....
(Signature)

(THIS END-OF-LIFE DECISIONS ADDENDUM WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO YOU KNOW AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE; OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the 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.

NOTARY
SEAL .....
(Signature)

STATEMENT OF WITNESSES

(If you choose to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. The following people cannot be used as a witness: (1) a person you designate as the agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; or (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 End-of-Life Decisions Addendum 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 agent by the power of attorney for health care and that I am not a provider of health care, an employee of a provider of health care, the operator of a health care facility or an employee of an operator of a health care facility.

Signature: ..... Residence Address: .....
Print Name: .....
Date: .....

Signature: ..... Residence Address: .....
Print Name: .....
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 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: .....

Signature: .....

Names: ..... Address: .....
Print Name: .....
Date: .....

COPIES: You should retain an executed copy of this document and give one to your agent. The End-of-Life Decisions Addendum should be available so a copy may be given to your providers of health care.

(Added to NRS by 2019, 1732)

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