

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_



**POWER OF ATTORNEY FOR HEALTHCARE**

I appoint \_\_\_\_\_ whose address is \_\_\_\_\_  
\_\_\_\_\_ and whose telephone number is \_\_\_\_\_ as my  
attorney in fact for healthcare. I appoint \_\_\_\_\_ whose address is  
\_\_\_\_\_ as my successor  
attorney in fact for healthcare. I authorize my attorney in fact appointed by this document to make  
healthcare decisions for me when I am determined to be incapable of making my own decisions. I  
direct that my attorney in fact comply with the following instructions or limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I instruct that my attorney in fact comply with the following instructions on artificially administered  
nutrition and hydration: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTHCARE. 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 HEALTHCARE AT ANY TIME BY  
NOTIFYING MY ATTORNEY IN FACT, 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 HEALTHCARE THAT THE FACT OF MY INCAPACITY IN  
THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

STATE OF NEBRASKA  
COUNTY OF \_\_\_\_\_

The declarant voluntarily signed this writing in my presence.

\_\_\_\_\_ Notary Public