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FIRST REPRINT **A.B. 414**

ASSEMBLY BILL NO. 414–ASSEMBLYWOMAN BACKUS

MARCH 27, 2023

Referred to Committee on Judiciary

SUMMARY—Revises provisions governing powers of attorney. (BDR 13-797)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to powers of attorney; defining certain words and terms relating to powers of attorney for health care; establishing a form to create an advance health-care directive; revising provisions concerning witnesses to a principal's signature of a power of attorney for health care; removing the requirement that, in certain circumstances, a certification of competency must be attached to a power of attorney; repealing provisions relating to the current form for powers of attorney for health care; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law sets forth provisions governing durable powers of attorney for health care decisions. (NRS 162A.700-162A.870) **Section 36** of this bill establishes a form to create an advance health-care directive that includes provisions relating to: (1) naming an agent and alternate agent and limiting an agent's authority; (2) health care instructions concerning life-sustaining treatment and certain priorities; (3) optional special powers of an agent, access to health information by an agent, additional guidance for an agent and the nomination of a guardian; (4) organ donation; and (5) certain information for agents. **Section 78** of this bill repeals the current form for powers of attorney for health care.

Existing law requires a power of attorney for health care to be signed by the principal, whose signature must be acknowledged by a notary public or witnessed by two adult witnesses who personally know the principal. Existing law also sets forth certain persons who are disqualified from being a witness to a principal's signature and establishes certain other requirements relating to such witnesses. Existing law further requires that a certification of competency of the principal be attached to a power of attorney if the principal lives in certain health care facilities. (NRS 162A.790) **Section 57.7** of this bill: (1) removes the requirement that the

witnesses to a principal's signature must personally know the principal; (2) provides that only the owner or operator or an employee of a nursing home in which the principal resides is disqualified from being a witness to the principal's signature; and (3) removes the requirement that a certification of competency must be attached to the power of attorney of a principal who lives in certain health care facilities.

Sections 5-19 of this bill define certain words and terms for the purposes of the provisions of law governing powers of attorney for health care decisions. **Sections 57.3 and 61-72** of this bill make conforming changes to indicate the proper placement of **sections 5-36** of this bill in the Nevada Revised Statutes.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. (Deleted by amendment.)

Sec. 2. Chapter 162A of NRS is hereby amended by adding thereto the provisions set forth as sections 3 to 56, inclusive, of this act.

Sec. 3. (Deleted by amendment.)

Sec. 4. (Deleted by amendment.)

Sec. 5. ***"Advance health-care directive" means a power of attorney for health care.***

Sec. 6. (Deleted by amendment.)

Sec. 7. (Deleted by amendment.)

Sec. 8. (Deleted by amendment.)

Sec. 9. ***"Guardian" means a person appointed under other law by a court to make decisions regarding the personal affairs of an individual, including, without limitation, health care decisions. The term does not include a guardian ad litem.***

Sec. 10. (Deleted by amendment.)

Sec. 11. ***"Health care" means care, treatment, service or procedure to maintain, monitor, diagnose or otherwise affect the physical or mental illness, injury or condition of an individual.***

Sec. 12. (Deleted by amendment.)

Sec. 13. (Deleted by amendment.)

Sec. 14. (Deleted by amendment.)

Sec. 15. (Deleted by amendment.)

Sec. 16. (Deleted by amendment.)

Sec. 17. (Deleted by amendment.)

Sec. 18. (Deleted by amendment.)

Sec. 19. ***"Nursing home" means a "nursing facility" as defined in 42 U.S.C. § 1396r(a), as amended, or "skilled nursing facility" as defined in 42 U.S.C. § 1395i–3(a), as amended.***

Sec. 20. (Deleted by amendment.)

Sec. 21. (Deleted by amendment.)

Sec. 22. (Deleted by amendment.)

Sec. 23. (Deleted by amendment.)
Sec. 24. (Deleted by amendment.)
Sec. 25. (Deleted by amendment.)
Sec. 26. (Deleted by amendment.)
Sec. 27. (Deleted by amendment.)
Sec. 28. (Deleted by amendment.)
Sec. 29. (Deleted by amendment.)
Sec. 30. (Deleted by amendment.)
Sec. 31. (Deleted by amendment.)
Sec. 32. (Deleted by amendment.)
Sec. 33. (Deleted by amendment.)
Sec. 34. (Deleted by amendment.)
Sec. 35. (Deleted by amendment.)
Sec. 36. ***The following form may be used to create an advance health-care directive.***

ADVANCE HEALTH-CARE DIRECTIVE
HOW YOU USE THIS FORM

You can use this form if you wish to name someone to make health care decisions for you in case you cannot make them for yourself. This is called giving the person you name a power of attorney for health care. The person you name is called your agent.

You can also use this form to state your wishes, preferences and goals for health care, and to say if you want to be an organ donor after you die.

YOUR NAME AND DATE OF BIRTH

Name:.....

Date of birth:.....

PART 1: NAMING AN AGENT

This part lets you name someone else to make health care decisions for you. You may leave any item blank.

(1) NAMING AN AGENT: I want the following person to make health care decisions for me if I cannot make decisions for myself:
Name:.....

Optional contact information (It is helpful to include information such as the person's address, phone number and email address.): .....
.....

(2) NAMING AN ALTERNATE AGENT: I want the following person to make health care decisions for me if I cannot and my agent is not willing, able or reasonably available to make them for me:

Name:.....
Optional contact information (It is helpful to include information such as the person's address, phone number and email address.): .....
.....

(3) LIMITING YOUR AGENT'S AUTHORITY: I give my agent the power to make all health care decisions for me if I cannot make those decisions for myself, except for the following:.....
.....
(If you do not add any limitations here, your agent will be able make all health care decisions that an agent is permitted to make under state law.)

PART 2: HEALTH CARE INSTRUCTION

This part lets you state your priorities for health care and types of health care you do and do not want.

(1) INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

This section gives you the opportunity to say how you want your agent to act while making decisions for you. You may mark or initial each item. You may also leave any item blank.

Medical treatment needed to keep me alive but not needed for comfort or any other purpose should (mark all that apply):

(__) Always be given to me.
(__) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
(__) Not be given to me if I am unconscious and I am not expected to be conscious again.
(__) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
(__) Other (write what you want or do not want):

If I cannot swallow and staying alive requires me to get liquid or food through a tube or other means for the rest of my life, liquid or food should (mark all that apply):
(__) Always be given to me.
(__) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
(__) Not be given to me if I am unconscious and I am not expected to be conscious again.
(__) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
(__) Other (write what you want or do not want):

If I am in significant pain, care that will keep me comfortable but is likely to shorten my life should (mark all that apply):
(__) Always be given to me.
(__) Never be given to me.
(__) Be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
(__) Be given to me if I am unconscious and I am not expected to be conscious again.
(__) Be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
(__) Other (write what you want or do not want):

(2) INSTRUCTION ABOUT PRIORITIES

You can use this section to indicate what is important to you, and what is not important to you. This information can help your agent make decisions for you if you cannot. It also helps others understand your preferences.

You may mark or initial each item. You also may leave any item blank.

Staying alive as long as possible even if I have substantial physical limitations is:
(__) very important
(__) somewhat important
(__) not important

Staying alive as long as possible even if I have substantial mental limitations is:
(__) very important
(__) somewhat important
(__) not important

Being free from significant pain is:
(__) very important
(__) somewhat important
(__) not important

Being independent is:
(__) very important
(__) somewhat important
(__) not important

Having my agent talk with my family before making decisions about my care is:
(__) very important
(__) somewhat important
(__) not important

Having my agent talk with my friends before making decisions about my care is:
(__) very important
(__) somewhat important
(__) not important

(3) OTHER INSTRUCTIONS

You can use this section to provide any other information about your goals, values and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.

PART 3: OPTIONAL SPECIAL POWERS AND GUIDANCE

This part allows you to give your agent additional powers and to provide your agent with more guidance about your wishes. You may mark or initial each item. You also may leave any item blank.

(1) OPTIONAL SPECIAL POWERS

My agent can do the following things ONLY if I have initialed or marked them below:

(__) Admit me as a voluntary patient to a facility for mental health treatment for up to 7 days, 14 days or 30 days (circle one).
(If I do not mark or initial this, my agent MAY NOT admit me as a voluntary patient to this type of facility.)

(__) Place me in a nursing home for more than 100 days even if my needs can be met somewhere else, I am not terminally ill and I object.
(If I do not mark or initial this, my agent MAY NOT do this.)

(2) ACCESS TO MY HEALTH INFORMATION

My agent may obtain, examine and share information about my health needs and health care if I am not able to make decisions for myself. If I initial or mark below, my agent may also do this at any time he or she thinks it will help me.

(__) I give my agent permission to obtain, examine and share information about my health needs and health care whenever he or she thinks it will help me.

(3) GUIDANCE FOR MY AGENT

The instructions I have stated in this document should guide my agent in making decisions for me (initial or mark one of the below items to tell your agent more about how to use these instructions):

(__) I give my agent permission to be flexible in applying these instructions if he or she thinks it would be in my best interest based on what they know about me.

(__) I want my agent to follow these instructions exactly as written if possible, even if he or she thinks something else is better.

(4) NOMINATION OF GUARDIAN

Here you can say who you would want as your guardian if you need one. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions. Filling this out does NOT mean you want or need a guardian right now.

If a court appoints a guardian to make personal decisions for me, I want the court to choose:

(__) My agent named in this form. If my agent cannot be a guardian, I want my alternate agent named in this form.

(__) Other (write who you would want and their contact information): .....

PART 4: ORGAN DONATION

This part allows you to donate your organs when you die. You may mark or initial each item. You also may leave any item blank.

Even if it requires maintaining treatments that could prolong my dying process and might be in conflict with other instructions I have put in this form, upon my death:

(__) I donate my organs, tissues and other body parts, except for those listed below (list any body parts you do not want to donate):.....
(__) I do not want my organs, tissues or body parts donated to anybody for any reason.

Organs, tissues or body parts that I donate may be used for:
(__) transplant
(__) therapy
(__) research
(__) education
(__) all of the above

PART 5: SIGNATURES REQUIRED ON THIS FORM

YOUR SIGNATURE

Sign your name: .....

Today's date:.....

SIGNATURE OF WITNESSES

You need two witnesses if you are using this form to name an agent. The witnesses must be adults and cannot be the person you are naming as agent. If you live in a nursing home, the witness cannot be an employee of the home or someone who owns or runs the home.

Witness name:.....

Witness signature: .....
.....

Date witness signed: .....
(Only sign as a witness if you think that the person signing above is doing it voluntarily.)

Witness name:.....

Witness signature: .....
.....
Date witness signed: .....
(Only sign as a witness if you think that the person signing above is doing it voluntarily.)

PART 6: INFORMATION FOR AGENTS

(1) If this form names you as an agent, you can make decisions about health care for the person who named you when they cannot make their own.

(2) If you make a decision for the person, follow any instructions the person gave, including any in this form.

(3) If you make a decision for the person and you don't know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences and goals if you know them or can learn them. Some of those preferences might be in this form. You should also consider any behaviors or communications from the person that indicate what they currently want.

(4) If this form names you as an agent, you can also get and share the individual's health information. But unless the person has said so in this form, you can only get or share this information when the person cannot make their own decisions about their health care.

Sec. 37. (Deleted by amendment.)
Sec. 38. (Deleted by amendment.)
Sec. 39. (Deleted by amendment.)
Sec. 40. (Deleted by amendment.)
Sec. 41. (Deleted by amendment.)
Sec. 42. (Deleted by amendment.)
Sec. 43. (Deleted by amendment.)
Sec. 44. (Deleted by amendment.)
Sec. 45. (Deleted by amendment.)
Sec. 46. (Deleted by amendment.)
Sec. 47. (Deleted by amendment.)
Sec. 48. (Deleted by amendment.)
Sec. 49. (Deleted by amendment.)
Sec. 50. (Deleted by amendment.)
Sec. 51. (Deleted by amendment.)
Sec. 52. (Deleted by amendment.)
Sec. 53. (Deleted by amendment.)
Sec. 54. (Deleted by amendment.)
Sec. 55. (Deleted by amendment.)
Sec. 56. (Deleted by amendment.)
Sec. 57. (Deleted by amendment.)

Sec. 57.3. NRS 162A.710 is hereby amended to read as follows:

162A.710 As used in NRS 162A.700 to 162A.870, inclusive, ***and sections 5 to 36, inclusive, of this act,*** unless the context otherwise requires, the words and terms defined in NRS 162A.720 to 162A.780, inclusive, ***and sections 5 to 19, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 57.7. NRS 162A.790 is hereby amended to read as follows:

162A.790 1. Any adult person may execute a power of attorney enabling the agent named in the power of attorney to make decisions concerning health care for the principal if that principal becomes incapable of giving informed consent concerning such decisions.

2. A power of attorney for health care must be signed by the principal. The principal's signature on the power of attorney for health care must be:

(a) Acknowledged before a notary public; or

(b) Witnessed by two adult witnesses **.** ~~[who know the principal personally.]~~

3. Neither of the witnesses to a principal's signature may be ~~[:~~

~~(a) A provider of health care;~~

~~(b) An employee of a provider of health care;~~

~~(c) An operator of a health care facility;~~

~~(d) An employee of a health care facility; or~~

~~(e) The agent.]~~ ***the owner, operator or employee of a nursing home if the principal resides in the nursing home.***

4. ~~[At least one of the witnesses to a principal's signature must be a person who is:~~

~~(a) Not related to the principal by blood, marriage or adoption; and~~

~~(b) To the best of the witnesses' knowledge, not entitled to any part of the estate of the principal upon the death of the principal.~~

~~5. If the principal resides in a hospital, residential facility for groups, facility for skilled nursing or home for individual residential care, at the time of the execution of the power of attorney, a certification of competency of the principal from an advanced practice registered nurse, a physician, psychologist or psychiatrist must be attached to the power of attorney.~~

~~6.]~~ A power of attorney executed in a jurisdiction outside of this State is valid in this State if, when the power of attorney was executed, the execution complied with the laws of that jurisdiction or the requirements for a military power of attorney pursuant to 10 U.S.C. § 1044b.

~~[7. As used in this section:~~

~~(a) "Facility for skilled nursing" has the meaning ascribed to it in NRS 449.0039.~~

~~(b) "Home for individual residential care" has the meaning ascribed to it in NRS 449.0105.~~

~~(c) "Hospital" has the meaning ascribed to it in NRS 449.012.~~

~~(d) "Residential facility for groups" has the meaning ascribed to it in NRS 449.017.~~]

Sec. 58. (Deleted by amendment.)

Sec. 59. (Deleted by amendment.)

Sec. 60. (Deleted by amendment.)

Sec. 61. NRS 433A.190 is hereby amended to read as follows:

433A.190 1. The administrative officer of a public or private mental health facility or hospital shall ensure that, within 24 hours of the emergency admission of a person alleged to be a person in a mental health crisis who is at least 18 years of age, the person is asked to give permission to provide notice of the emergency admission to a family member, friend or other person identified by the person.

2. If a person alleged to be a person in a mental health crisis who is at least 18 years of age gives permission to notify a family member, friend or other person of the emergency admission, the administrative officer shall ensure that:

(a) The permission is recorded in the medical record of the person; and

(b) Notice of the admission is promptly provided to the family member, friend or other person in person or by telephone, facsimile, other electronic communication or certified mail.

3. Except as otherwise provided in subsections 4 and 5, if a person alleged to be a person in a mental health crisis who is at least 18 years of age does not give permission to notify a family member, friend or other person of the emergency admission of the person, notice of the emergency admission must not be provided until permission is obtained.

4. If a person alleged to be a person in a mental health crisis who is at least 18 years of age is not able to give or refuse permission to notify a family member, friend or other person of the emergency admission, the administrative officer of the mental health facility or hospital may cause notice as described in paragraph (b) of subsection 2 to be provided if the administrative officer determines that it is in the best interest of the person in a mental health crisis.

5. If a guardian has been appointed for a person alleged to be a person in a mental health crisis who is at least 18 years of age or the person has executed a durable power of attorney for health care pursuant to NRS 162A.700 to 162A.870, inclusive, ***and sections 3 to 56, inclusive, of this act*** or appointed an attorney-in-fact using an

advance directive for psychiatric care pursuant to NRS 449A.600 to 449A.645, inclusive, the administrative officer of the mental health facility or hospital must ensure that the guardian, agent designated by the durable power of attorney or the attorney-in-fact, as applicable, is promptly notified of the admission as described in paragraph (b) of subsection 2, regardless of whether the person alleged to be a person in a mental health crisis has given permission to the notification.

Sec. 62. (Deleted by amendment.)

Sec. 63. (Deleted by amendment.)

Sec. 64. NRS 449A.309 is hereby amended to read as follows:

449A.309 "Representative of the patient" means a legal guardian of the patient, a person designated by the patient to make decisions governing the withholding or withdrawal of life-sustaining treatment pursuant to NRS 449A.433 or a person given power of attorney to make decisions concerning health care for the patient pursuant to NRS 162A.700 to 162A.870, ~~[inclusive.]~~ ***inclusive, and sections 3 to 56, inclusive, of this act.***

Sec. 65. (Deleted by amendment.)

Sec. 66. (Deleted by amendment.)

Sec. 67. NRS 449A.545 is hereby amended to read as follows:

449A.545 "Representative of the patient" means a legal guardian of the patient, a person designated by the patient to make decisions governing the withholding or withdrawal of life-sustaining treatment pursuant to NRS 449A.433 or a person given power of attorney to make decisions concerning health care for the patient pursuant to NRS 162A.700 to 162A.870, inclusive ~~[.]~~ ***, and sections 3 to 56, inclusive, of this act.***

Sec. 68. NRS 449A.621 is hereby amended to read as follows:

449A.621 The form of an advance directive for psychiatric care may be substantially in the following form, and must be witnessed or executed in the same manner as the following form:

NOTICE TO PERSON MAKING AN ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES AN ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT ALLOWS YOU TO MAKE DECISIONS IN ADVANCE ABOUT CERTAIN TYPES OF PSYCHIATRIC CARE. THE INSTRUCTIONS YOU INCLUDE IN THIS ADVANCE DIRECTIVE WILL BE

FOLLOWED IF TWO PROVIDERS OF HEALTH CARE, ONE OF WHOM MUST BE A PHYSICIAN OR LICENSED PSYCHOLOGIST AND THE OTHER OF WHOM MUST BE A PHYSICIAN, A PHYSICIAN ASSISTANT, A LICENSED PSYCHOLOGIST, A PSYCHIATRIST OR AN ADVANCED PRACTICE REGISTERED NURSE WHO HAS THE PSYCHIATRIC TRAINING AND EXPERIENCE PRESCRIBED BY THE STATE BOARD OF NURSING PURSUANT TO NRS 632.120, DETERMINES THAT YOU ARE INCAPABLE OF MAKING OR COMMUNICATING TREATMENT DECISIONS. OTHERWISE YOU WILL BE CONSIDERED CAPABLE TO GIVE OR WITHHOLD CONSENT FOR THE TREATMENTS. YOUR INSTRUCTIONS MAY BE OVERRIDDEN IF YOU ARE BEING HELD IN ACCORDANCE WITH CIVIL COMMITMENT LAW. BY EXECUTING A DURABLE POWER OF ATTORNEY FOR HEALTH CARE AS SET FORTH IN NRS 162A.700 TO 162A.870, INCLUSIVE, ***AND SECTIONS 3 TO 56, INCLUSIVE, OF THIS ACT,*** YOU MAY ALSO APPOINT A PERSON AS YOUR AGENT TO MAKE TREATMENT DECISIONS FOR YOU IF YOU BECOME INCAPABLE. THIS DOCUMENT IS VALID FOR TWO YEARS FROM THE DATE YOU EXECUTE IT UNLESS YOU REVOKE IT. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT AT ANY TIME YOU HAVE NOT BEEN DETERMINED TO BE INCAPABLE. YOU MAY NOT REVOKE THIS ADVANCE DIRECTIVE WHEN YOU ARE FOUND INCAPABLE BY TWO PROVIDERS OF HEALTH CARE, ONE OF WHOM MUST BE A PHYSICIAN OR LICENSED PSYCHOLOGIST AND THE OTHER OF WHOM MUST BE A PHYSICIAN, A PHYSICIAN ASSISTANT, A LICENSED PSYCHOLOGIST, A PSYCHIATRIST OR AN ADVANCED PRACTICE REGISTERED NURSE WHO HAS THE PSYCHIATRIC TRAINING AND EXPERIENCE PRESCRIBED BY THE STATE BOARD OF NURSING PURSUANT TO NRS 632.120. A REVOCATION IS EFFECTIVE WHEN IT IS COMMUNICATED TO YOUR ATTENDING PHYSICIAN OR OTHER HEALTH CARE PROVIDER. THE PHYSICIAN OR OTHER PROVIDER SHALL NOTE THE REVOCATION IN YOUR MEDICAL RECORD. TO BE VALID, THIS ADVANCE DIRECTIVE MUST BE SIGNED BY TWO QUALIFIED WITNESSES, PERSONALLY KNOWN TO YOU, WHO ARE PRESENT

WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IT MUST ALSO BE ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

NOTICE TO PHYSICIAN OR OTHER PROVIDER OF HEALTH CARE

Under Nevada law, a person may use this advance directive to provide consent or refuse to consent to future psychiatric care if the person later becomes incapable of making or communicating those decisions. By executing a durable power of attorney for health care as set forth in NRS 162A.700 to 162A.870, inclusive, ***and sections 3 to 56, inclusive, of this act,*** the person may also appoint an agent to make decisions regarding psychiatric care for the person when incapable. A person is "incapable" for the purposes of this advance directive when in the opinion of two providers of health care, one of whom must be a physician or licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120, the person currently lacks sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. If a person is determined to be incapable, the person may be found capable when, in the opinion of the person's attending physician or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120 and has an established relationship with the person, the person has regained sufficient understanding or capacity to make or communicate decisions regarding psychiatric care. This document becomes effective upon its proper execution and remains valid for a period of 2 years after the date of its execution unless revoked. Upon being presented with this advance directive, the physician or other provider of health care must make it a part of the person's medical record. The physician or other provider must act in accordance with the statements expressed in the advance directive when the person is determined to be incapable, except as otherwise provided in NRS 449A.636. The physician or other provider shall promptly notify the principal and, if applicable, the agent of the principal, and document in the principal's medical record any act or omission that is not in compliance with any part of

an advance directive. A physician or other provider may rely upon the authority of a signed, witnessed, dated and notarized advance directive.

ADVANCE DIRECTIVE FOR PSYCHIATRIC CARE

I, ..., being an adult of sound mind or an emancipated minor, willfully and voluntarily make this advance directive for psychiatric care to be followed if it is determined by two providers of health care, one of whom must be my attending physician or a licensed psychologist and the other of whom must be a physician, a physician assistant, a licensed psychologist, a psychiatrist or an advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120, that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to psychiatric care. I understand that psychiatric care may not be administered without my express and informed consent or, if I am incapable of giving my informed consent, the express and informed consent of my legally responsible person, my agent named pursuant to a valid durable power of attorney for health care or my consent expressed in this advance directive for psychiatric care. I understand that I may become incapable of giving or withholding informed consent or refusal for psychiatric care due to the symptoms of a diagnosed mental disorder. These symptoms may include:

.....

PSYCHOACTIVE MEDICATIONS

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding psychoactive medications are as follows: (Place initials beside choice.)

I consent to the administration of the following medications: [.....]

.....

I do not consent to the administration of the following medications: [.....]

.....

Conditions or limitations:

.....

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for psychiatric care, my instructions regarding admission to and retention in a medical facility for psychiatric care are as follows: (Place initials beside choice.)

I consent to being admitted to a medical facility for psychiatric care. [.....]

My facility preference is:

.....

I do not consent to being admitted to a medical facility for psychiatric care. [.....]

This advance directive cannot, by law, provide consent to retain me in a facility beyond the specific number of days, if any, provided in this advance directive.

Conditions or limitations:

.....

ADDITIONAL INSTRUCTIONS

These instructions shall apply during the entire length of my incapacity.

In case of a mental health crisis, please contact:

1.
   Name: .....
   Address: .....
   Home Telephone Number: .....
   Work Telephone Number: .....
   Relationship to Me: .....

2.
   Name: .....
   Address: .....
   Home Telephone Number: .....
   Work Telephone Number: .....
   Relationship to Me: .....

3. My physician:
   Name: .....
   Work Telephone Number: .....

4. My therapist or counselor:
   Name: .....
   Work Telephone Number: .....

The following may cause me to experience a mental health crisis:

.....

The following may help me avoid a hospitalization:

.....

I generally react to being hospitalized as follows:

.....

Staff of the hospital or crisis unit can help me by doing the following:

.....

I give permission for the following person or people to visit me:

.....

Instructions concerning any other medical interventions, such as electroconvulsive (ECT) treatment (commonly referred to as "shock treatment"):

.....

Other instructions:

.....

I have attached an additional sheet of instructions to be followed and considered part of this advance directive. [.....]

SHARING OF INFORMATION BY PROVIDERS

I understand that the information in this document may be shared by my provider of mental health care with any other provider who may serve me when necessary to provide treatment in accordance with this advance directive.

Other instructions about sharing of information:

.....

SIGNATURE OF PRINCIPAL

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full impact of having made this advance directive for psychiatric care.

....

Signature of Principal Date

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this advance directive for psychiatric care in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is:

1. A person appointed as an attorney-in-fact by this document;
2. The principal's attending physician or provider of health care or an employee of the physician or provider; or
3. The owner or operator, or employee of the owner or operator, of a medical facility in which the principal is a patient or resident.

Witnessed by:

Witness: ....
Signature Date

Witness: ....
Signature Date

~~[STATE OF NEVADA~~
~~COUNTY OF .....]~~

CERTIFICATION OF NOTARY PUBLIC

STATE OF NEVADA
COUNTY OF .....

I, ..., a Notary Public for the County cited above in the State of Nevada, hereby certify that ..... appeared before me and swore or affirmed to me and to the witnesses in my presence that this instrument is an advance directive for psychiatric care and that he or she willingly and voluntarily made and executed it as his or her free act and deed for the purposes expressed in it.

I further certify that ..... and ....., witnesses, appeared before me and swore or affirmed that each witnessed ..... sign the attached advance directive for psychiatric care believing him or her to be of sound mind and also swore that at the time each witnessed the signing, each person was: (1) not the attending physician or provider of health care, or an employee of the physician or provider, of the principal; (2) not the owner or operator, or employee of the owner or operator, of a

medical facility in which the principal is a patient or resident; and (3) not a person appointed as an attorney-in-fact by the attached advance directive for psychiatric care. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This is the ..... day of ....., ...

.....

Notary Public

My Commission expires: .....

Sec. 69. NRS 449A.703 is hereby amended to read as follows:

449A.703 "Advance directive" means an advance directive for health care. The term includes:

1. A declaration governing the withholding or withdrawal of life-sustaining treatment as set forth in NRS 449A.400 to 449A.481, inclusive;

2. A durable power of attorney for health care as set forth in NRS 162A.700 to 162A.870, inclusive ~~[.]~~ ***, and sections 3 to 56, inclusive, of this act;***

3. An advance directive for psychiatric care as set forth in NRS 449A.600 to 449A.645, inclusive;

4. A do-not-resuscitate order as defined in NRS 450B.420; and

5. A Provider Order for Life-Sustaining Treatment form as defined in NRS 449A.542.

Sec. 70. NRS 449A.727 is hereby amended to read as follows:

449A.727 1. The provisions of NRS 449A.700 to 449A.739, inclusive, do not require a provider of health care to inquire whether a patient has an advance directive registered on the Registry or to access the Registry to determine the terms of the advance directive.

2. A provider of health care who relies in good faith on the provisions of an advance directive retrieved from the Registry is immune from criminal and civil liability as set forth in:

(a) NRS 449A.460, if the advance directive is a declaration governing the withholding or withdrawal of life-sustaining treatment executed pursuant to NRS 449A.400 to 449A.481, inclusive, or a durable power of attorney for health care executed pursuant to NRS 162A.700 to 162A.870, inclusive ~~[.]~~ ***, and sections 3 to 56, inclusive, of this act.***

(b) NRS 449A.642, if the advance directive is an advance directive for psychiatric care executed pursuant to NRS 449A.600 to 449A.645, inclusive;

(c) NRS 449A.500 to 449A.581, inclusive, if the advance directive is a Provider Order for Life-Sustaining Treatment form; or

(d) NRS 450B.540, if the advance directive is a do-not-resuscitate order as defined in NRS 450B.420.

Sec. 71. (Deleted by amendment.)

Sec. 72. NRS 450B.520 is hereby amended to read as follows:

450B.520 Except as otherwise provided in NRS 450B.525:

1. A qualified patient may apply to the health authority for a do-not-resuscitate identification by submitting an application on a form provided by the health authority. To obtain a do-not-resuscitate identification, the patient must comply with the requirements prescribed by the board and sign a form which states that the patient has informed each member of his or her family within the first degree of consanguinity or affinity, whose whereabouts are known to the patient, or if no such members are living, the patient's legal guardian, if any, or if he or she has no such members living and has no legal guardian, his or her caretaker, if any, of the patient's decision to apply for an identification.

2. An application must include, without limitation:

(a) Certification by the patient's attending physician or attending advanced practice registered nurse that the patient suffers from a terminal condition;

(b) Certification by the patient's attending physician or attending advanced practice registered nurse that the patient is capable of making an informed decision or, when the patient was capable of making an informed decision, that the patient:

(1) Executed:

(I) A written directive that life-resuscitating treatment be withheld under certain circumstances;

(II) A durable power of attorney for health care pursuant to NRS 162A.700 to 162A.870, inclusive ~~[,]~~ ***, and sections 3 to 56, inclusive, of this act;*** or

(III) A Provider Order for Life-Sustaining Treatment form pursuant to NRS 449A.500 to 449A.581, inclusive, if the form provides that the patient is not to receive life-resuscitating treatment; or

(2) Was issued a do-not-resuscitate order pursuant to NRS 450B.510;

(c) A statement that the patient does not wish that life-resuscitating treatment be undertaken in the event of a cardiac or respiratory arrest;

(d) The name, signature and telephone number of the patient's attending physician or attending advanced practice registered nurse; and

(e) The name and signature of the patient or the agent who is authorized to make health care decisions on the patient's behalf pursuant to a durable power of attorney for health care decisions.

Sec. 73. (Deleted by amendment.)

Sec. 74. (Deleted by amendment.)

Sec. 75. (Deleted by amendment.)

Sec. 76. (Deleted by amendment.)

Sec. 77. 1. The provisions of this act apply to an advance health-care directive created before, on or after January 1, 2024.

2. An advance health-care directive created before January 1, 2024, is valid if it complies with the provisions of this act or complied at the time of creation with the law of the state in which it was created.

3. The provisions of this act do not affect the validity or effect of an act done before January 1, 2024.

4. An individual who assumed authority to act as a default surrogate before January 1, 2024, may continue to act as a default surrogate until the individual for whom the default surrogate is acting no longer lacks capacity or the default surrogate is disqualified, whichever occurs first.

5. An advance health-care directive created before, on or after January 1, 2024, must be interpreted in accordance with the law of this State, excluding the State's choice-of-law rules, at the time the directive is implemented.

Sec. 78. NRS 162A.860 is hereby repealed.

Sec. 79. This act becomes effective on January 1, 2024.

TEXT OF REPEALED SECTION

162A.860 Power of attorney: Form. Except as otherwise provided in NRS 162A.865 and 162A.870, the form of a power of attorney for health care 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

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 OR ADVANCED PRACTICE REGISTERED NURSE 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 DECIDE WHERE YOU LIVE, EVEN AS YOU AGE. DECISIONS ABOUT WHERE YOU LIVE ARE PERSONAL. SOME PEOPLE

LIVE AT HOME WITH SUPPORT, WHILE OTHERS MOVE TO ASSISTED LIVING FACILITIES OR FACILITIES FOR SKILLED NURSING. IN SOME CASES, PEOPLE ARE MOVED TO FACILITIES WITH LOCKED DOORS TO PREVENT PEOPLE WITH COGNITIVE DISORDERS FROM LEAVING OR GETTING LOST OR TO PROVIDE ASSISTANCE TO PEOPLE WHO REQUIRE A HIGHER LEVEL OF CARE. YOU SHOULD DISCUSS WITH THE PERSON DESIGNATED IN THIS DOCUMENT YOUR DESIRES ABOUT WHERE YOU LIVE AS YOU AGE OR IF YOUR HEALTH DECLINES. YOU HAVE THE RIGHT TO DETERMINE WHETHER TO AUTHORIZE THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE DECISIONS FOR YOU ABOUT WHERE YOU LIVE WHEN YOU ARE NO LONGER CAPABLE OF MAKING THAT DECISION. IF YOU DO NOT PROVIDE SUCH AUTHORIZATION TO THE PERSON DESIGNATED IN THIS DOCUMENT, THAT PERSON MAY NOT BE ABLE TO ASSIST YOU TO MOVE TO A MORE SUPPORTIVE LIVING ARRANGEMENT WITHOUT OBTAINING APPROVAL THROUGH A JUDICIAL PROCESS.

7. 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.

8. 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, ADVANCED PRACTICE REGISTERED NURSE, HOSPITAL OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

9. 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.

10. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

11. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

12. YOU MAY REQUEST THAT THE NEVADA SECRETARY OF STATE ELECTRONICALLY STORE WITH THE NEVADA LOCKBOX A COPY OF THIS DOCUMENT TO ALLOW ACCESS BY AN AUTHORIZED PROVIDER OF HEALTH CARE AS DEFINED IN NRS 629.031.

1. DESIGNATION OF HEALTH CARE AGENT.

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

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 is also 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 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 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 PROVISIONS 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 agent's 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 agent 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 CONCERNING TREATMENT.

(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 box next to the statement.)

A. 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. [.....]

B. If I am in a coma which my doctors or advanced practice registered nurses have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. [.....]

C. 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. [.....]

D. 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 gastrointestinal tract after all other treatment is withheld. [.....]

E. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My agent 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. [.....]

F. If I have an incurable or terminal condition, including late stage dementia, or illness and no reasonable hope of long-term recovery or survival, I desire my attending physician to administer any medication to alleviate suffering without regard that the medication is likely to cause addiction or reduce the 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. STATEMENT OF DESIRES CONCERNING LIVING ARRANGEMENTS

A. I desire to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my activities of daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me. [.....]

B. I desire to live in my home for as long as possible without regard for my medical needs, personal safety or ability to engage in activities of daily

living. My agent may arrange for a natural person, an employee of an agency or a provider of community-based services to come into my home and provide care for me. I understand that, before I may be placed in a facility or home other than the home in which I currently reside, a guardian must be appointed for me. [.....]

(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: .....
.....
.....
.....
.....

8. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 2, 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 Alternative Agent
Name: .....
Address: .....
Telephone Number: .....

B. Second Alternative Agent
Name: .....
Address: .....
Telephone Number: .....

9. PRIOR DESIGNATIONS REVOKED.

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

10. 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.

11. CHALLENGES.

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, my advanced practice registered nurse, 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. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

12. NOMINATION OF GUARDIAN.

If, after execution of this Durable Power of Attorney for Health Care, proceedings seeking an adjudication of incapacity 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.

13. 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.

(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 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 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 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. This includes requesting the Nevada Secretary of State to electronically store this document with the Nevada Lockbox to allow access by authorized providers of healthcare.

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