NEBRASKA
POWER OF ATTORNEY FOR HEALTH CARE

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Nebraska
Power of Attorney for Health Care

1. I appoint ____, whose address is ____ and whose telephone number is ___________________________ as my attorney-in-fact for health care. I appoint ____, whose address is ____, and whose telephone number is _________________, as my successor attorney-in-fact for health care. I authorize my attorney-in-fact 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 have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

2. I direct that my attorney-in-fact comply with the following instructions or limitations:
____
____
____

3. I direct that my attorney-in-fact comply with the following instructions on life-sustaining treatment: (optional) ____

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____

4. I direct that my attorney-in-fact 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, 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.

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(Signature of person making designation/date)

Declaration of Witnesses

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

Witnessed By:

______________________________	______________________________
(Signature of Witness/Date)	(Printed Name of Witness)
______________________________	______________________________
(Signature of Witness/Date)	(Printed Name of Witness)

OR

State of Nebraska)
) ss,
County of ___________________________)

On this _____ day of ______________________ 20 __, before me, _______________ __________________________, a notary public in and for ___________________________ County, personally came _________________________________, personally known to be the identical person whose name is affixed to the above power of attorney for health care as principal, and I declare that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney-in-fact or successor attorney-in-fact designated by this power of attorney for health care.

Witness my hand and notarial seal at _______________________ in such county the day and year last above written.

____
Notary Public

CRITICAL STEP:
SHARE YOUR COMPLETED DOCUMENT!

Your document is only helpful if people know where to find it when it is needed. It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

WHO NEEDS A COPY OF YOUR DOCUMENT?

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

HOW TO SHARE YOUR DOCUMENT

1) **Use Cake!** Upload your document to a free Cake account for safekeeping.
   Share 24/7 secure document access with anyone that has an email address*

   Create your free Cake account: www.joincake.com/share-free

2) **Or, print** and provide copies to everyone who needs one

WHY PLAN & SHARE WITH CAKE?

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address*

Create your free Cake account: www.joincake.com/share-free

** Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*