Amendment No. 99

Assembly Amendment to Assembly Bill No. 128 (BDR 13-418)
Proposed by: Assembly Committee on Judiciary
Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐	_____	Adopted ☐	Lost ☐	_____
Concurred In ☐	Not ☐	_____	Concurred In ☐	Not ☐	_____
Receded ☐	Not ☐	_____	Receded ☐	Not ☐	_____

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

MKM/BAW Date: 4/19/2015

A.B. No. 128—Creates a power of attorney for health care decisions for adults with intellectual disabilities. (BDR 13-418)

ASSEMBLY BILL NO. 128–COMMITTEE ON JUDICIARY

(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON SENIOR CITIZENS, VETERANS AND ADULTS WITH SPECIAL NEEDS)

FEBRUARY 6, 2015

Referred to Committee on Judiciary

SUMMARY—Creates a power of attorney for health care decisions for adults with intellectual disabilities. (BDR 13-418)

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; creating a power of attorney for health care decisions for adults with intellectual disabilities; 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.860) Existing law specifically provides an example of a form for a power of attorney for health care. (NRS 162A.860) **Section 3** of this bill provides ~~[an example]~~ **examples** of a form for a power of attorney for health care for adults with intellectual disabilities ~~[.]~~ **and a form for end-of-life decisions for adults with intellectual disabilities.**

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

Section 1. Chapter 162A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***"Intellectual disability" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.***

Sec. 3. ***1. The form of a power of attorney for health care for an adult with an intellectual disability 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 ~~[to make]~~ for health care decisions for you) as my agent ~~[to make]~~ 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 me about my sickness or injury and whether I need any medicine or other treatment. After ~~[my agent speaks]~~ we speak with the doctor, I would like my agent to ~~[decide what care or treatment I should receive and]~~ speak with me about ~~[that]~~ 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. ~~[I would also like the doctor at the hospital to speak with my agent about what care or treatment I should receive.]~~ After ~~[my agent speaks]~~ we speak with the doctor, I would like my agent to help me decide what care or treatment I should receive . ~~[and, if I am able to communicate, speak with me about that care or treatment.]~~ 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 him or her that they are 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 449.766;

(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. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

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 an intellectual disability 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. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

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.

Sec. 4. NRS 162A.700 is hereby amended to read as follows:

162A.700 NRS 162A.700 to ~~[162A.860,]~~ ***162A.850,*** inclusive, ***and section 2 of this act*** apply to any power of attorney containing the authority to make health care decisions.

Sec. 5. NRS 162A.710 is hereby amended to read as follows:

162A.710 As used in NRS 162A.700 to 162A.860, inclusive, ***and sections 2 and 3 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 162A.720 to 162A.780, inclusive, ***and section 2 of this act*** have the meanings ascribed to them in those sections.

Sec. 6. NRS 162A.860 is hereby amended to read as follows:

162A.860 ~~[The]~~ ***Except as otherwise provided in section 3 of this act, 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 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 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.

7. 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, HOSPITAL OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

8. 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.

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

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

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.

(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.)

1. 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. [.....]

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.) [.....]

3. 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. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.) [.....]

4. 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. [.....]

5. 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. [.....]

(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. 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: .....

8. PRIOR DESIGNATIONS REVOKED.

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

9. 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.

10. CHALLENGES.

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, 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.

11. NOMINATION OF GUARDIAN.

If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings 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.

12. 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. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

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 ~~[community]~~ ***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.

Sec. 7. This act becomes effective upon passage and approval.