POWER OF ATTORNEY FOR HEALTH CARE

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.

I direct that my attorney in fact comply with the following instructions or limitations: _____

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

I direct that my attorney in fact comply with the following instructions on artificially administered nutrition and hydration: (optional) _____

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.

_____

(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, 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 to me 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 appears in sound mind and not under duress or undue influence, 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.

Signature of Notary Public _____

Seal