The following is the form of a “Durable Power of Attorney for Healthcare Decisions” provided for under the Nevada Statutes:

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

WARNING TO PERSONS 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 documents 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 the 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.

INITIALS_____

1. DESIGNATION OF HEALTH CARE AGENT:

I, Rickey Sorensen do hereby designate and appoint:

Name:

____

Address:

____

____

Telephone(s):____

____

___________________________________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.)

INITIALS_____

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 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, 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 <u>other restrictions you wish to place on your Agent's authority, you should list them in the space below</u>. 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 t the following special provisions and limitations:

I would like to have everything done at this time, yet I understand my condition is terminal. I agree if I will not be able to be taken off the ventilator I will want life support withdrawn. My physicians will determine if I will not be able to be taken off the ventilator. I am aware of my prognosis and I know that the physicians will do there best and it comes a point even on the ventilator my body is failing I agree to withdraw from all life support even knowing this will end in my life and cause death.

____

INITIALS_____

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 durable power of attorney for healthcare end on the following: Date: _________________ **Initials _____ Request Indefinite**

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 interest; and, under some circumstances, a judicial proceedings may be necessary so that a court can determine the health care decision that is in your best interests.

(If you wish to change your answer, you may do by drawing an “X” through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires

____

____

____

____

INITIALS_____

Place your initials in the appropriate box:

(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.

☐ I agree ☐ I disagree

(b). If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining treatments not be used. (Also should utilize provisions of NRS449.535 to 449.690, inclusive, if agreement is initialed.)

☐ I agree ☐ I disagree

(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. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if agreement is initialed.)

☐ I agree ☐ I disagree

INITIALS_____

(Continued- **Please place your initial in the appropriate box**)

(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.

☐ I agree ☐ I disagree

(e). I do not desire treatment to be provided and/or continued if the burdens to 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.

☐ I agree ☐ I disagree

(f). I direct my attending physician to mercifully administer such medication to me as will alleviate any suffering I might experience regardless of whether such medication is highly additive or may shorten my remaining life.

☐ I agree ☐ I disagree

7. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternative Agent but you may do so. Any alternate Agent designate will be able to make the same health care decisions as the Agent designated in paragraph 1, page 1, 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). **Second Choice as Agent**

Name: ____

Address: ____

____

Telephone Number(s): ______________________________________

____

(b). **Third Choice as Agent**

Name: ____

Address: ____

____

Telephone Number(s): ______________________________________

____

8. PRIOR DESIGATIONS 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 of the person______________________________ and as my guardian of the

estate ___________________________________ for consideration by the court.

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 (HIPAA), Public Law 104-191, as amended, and applicable regulations.

INITIALS_____

(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) Print name: ________________________

____
(Signature)

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLDGMENT 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 this 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.

____
(Signature of Notary Public)
Stamp of Notary Public INITIALS_____

DIRECTIVE TO PHYSICIAN

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to NRS 449.535 to 449.690, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

*   *   *

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial the box below **IF YOU WANT** to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld pursuant to this declaration.

☐

DATE: ______________________________

Signature: __________________________

Area for Notary:

PRINT NAME: ________________________

Address: ________________________

____

____

The declarant voluntarily signed this writing in my presence.

Witness __________________________ Witness __________________________

Address: __________________________ Address: _________________________

__________________________________ __________________________________

INITIALS_____

(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) Print name: ______________________

(Signature)____

(Please see page 2 as to who is not to be your agent or your witnesses.)
Two witnesses (instead of a notary) are to confirm patient is lucid, willing, and aware of what they are signing and witness signature of _______________________________________:

First Witness /Name: ____

Address: ____
____

Phone number: ____

Signature: ____

Date: __________________________

Second Witness/ Name: _______________________________________

Address: ____
____

Phone number: ____

Signature: ____

Date: __________________________

INITIALS_____