POWER OF ATTORNEY FOR HEALTH CARE FORM

I, [print name] _____ being of sound mind, an adult of at least 19 years of age or older, and a resident Nebraska, willfully and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows.

(1) I understand that my Power of Attorney for Health Care may include the selection of an attorney-in-fact in addition to setting forth my choices regarding health care.

(2 The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. The second physician or licensed clinical psychologist shall not be currently involved in my treatment, unless a second physician or licensed clinical psychologist uninvolved in my treatment is not reasonably available. Such certification shall be required before health care is provided, continued, withheld or withdrawn; before any attorney in fact shall be granted authority to make health care decisions on my behalf; and before, or as soon as reasonably practicable after, health care is provided, continued, withheld or withdrawn and every 180 days thereafter while the need for health care continues.

(3) If at any time I am determined to be incapable of making an informed decision, I shall be notified, to the extent I am capable of receiving such notice, that such a determination has been made before health care is provided, continued, withheld or withdrawn. Such notice also shall be provided, as soon as practicable, to my attorney in fact or person to make health care decisions on my behalf. If I am later determined to be capable of making an informed decision by a physician, in writing, upon personal examination, then any further health care decisions will require my informed consent.

(4) This Power of Attorney for Health Care shall not terminate in the event of my disability.

(5) This Power of Attorney for Health Care reflects my wishes, and I ask the medical and legal authorities in every state and country to respect them.

(6) I intend this Power of Attorney for Health Care to be construed in accordance with my religious beliefs and my basic values and in accordance with the laws of Nebraska.

(7) Any prior appointment of an attorney in fact, including an appointment that may be made in a document called a "living will" or "durable power of attorney for health care" or "health care proxy," is revoked.

SECTION I: APPOINTMENT OF ATTORNEY IN FACT

A. APPOINTMENT OF MY ATTORNEY IN FACT

I appoint the following person as my primary attorney in fact to make any health care decisions for me as authorized in this Advance Medical Directive consistent with the instructions below:

Name of primary attorney in fact (printed): _____

Address (printed): _____

Telephone: _____

CONTINUED

If the primary attorney in fact I appoint above is not reasonably available or is unable or unwilling to act as my attorney in fact, then I appoint, as my First Successor Attorney in Fact:

Name of 1st Successor Attorney in Fact (printed): _____

Address (printed): _____

Telephone: _____

If neither the primary attorney in fact nor the First Successor Attorney in Fact I appoint above is reasonably available, or if neither is willing to act as my attorney in fact, then I appoint, as my Second Successor Attorney in Fact:

Name of 2nd Successor Attorney in Fact (printed): _____

Address (printed): _____

Telephone: _____

B. POWERS GRANTED TO MY ATTORNEY IN FACT

I hereby grant to my attorney in fact, named above, full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment.

The powers of my attorney in fact shall include the following:

(1) To visit me in any institution to which I have been transported for emergency care or admitted for inpatient or outpatient health care, and to authorize visitation subject to physician orders and policies of the institution to which I have been transported or admitted.

(2) To consent to, refuse, or withdraw any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function consistent with my instructions below.

(3) To request, receive and review any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information.

(4) To employ and discharge my health care providers.

(5) To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, other health care facility, or mental health facility.

(6) To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided that I do not protest the admission and provided that a physician on the staff of or designated by the proposed admitting facility examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.

(7) To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to health care providers.

CONTINUED

(8) To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me, or if the study aims to increase scientific understanding of any condition, even though it offers no prospect of direct benefit to me.

C. DURATION AND SCOPE OF ATTORNEY IN FACT

(1) My attorney in fact's authority hereunder is effective as long as I am incapable of making an informed decision.

(2) In exercising the power to make health care decisions on my behalf, my attorney in fact shall follow my desires and preferences as stated in this document or in matters not addressed by my instructions in this document, as otherwise known to my attorney in fact. My attorney in fact shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, side effects, benefits and alternatives associated with treatment or non-treatment. My attorney in fact shall not authorize a course of treatment which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing.

(3) My attorney in fact shall not be liable for the costs of treatment pursuant to my attorney in fact's authorization, based solely on that authorization.

(4) My attorney in fact shall have the continued authority to serve as my attorney in fact even in the event that I protest the attorney in fact's authority after I have been determined to be incapable of making an informed decision.

SECTION II: INSTRUCTIONS ABOUT MY HEALTH CARE TO MY ATTORNEY IN FACT(S) AND ALL MEDICAL PERSONNEL

A. GENERAL INSTRUCTIONS: A PRESUMPTION FOR LIFE

(1) My desires and preferences are grounded in the Judeo-Christian moral tradition, which views human life as a gift of a loving God. This tradition further respects the life of each and every human being because each human being is made in the image and likeness of God and therefore it has a special value and significance.

(2) I believe that I have come from God and will return to God – in God's time and in God's way, not mine.

(3) As a member of the Catholic Church, I wish to follow the moral teachings of the Church, or though not a member of the Catholic Church, I nonetheless direct my attorney in fact to adhere to the moral teachings of the Catholic Church when making health care decisions on my behalf. I wish to receive all the obligatory care that my faith teaches we have a duty to accept. I also believe that Jesus has conquered sin so that death has lost its sting (1 Cor. 15:55) and that death need not be resisted by any and every means and that I have the right to refuse medical treatment that is excessively burdensome and would only prolong my death. I also know that I may morally receive medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life. I direct that those caring for me avoid doing anything which is contrary to the moral teachings of the Catholic Church. Those making decisions on my behalf shall be guided by the moral teachings of the Catholic Church, including the teachings contained in the Archdiocese of Omaha's question-and-answer guide. If my health care providers are unfamiliar with such teachings or authoritative Church references, I request that a certified Catholic chaplain or a Catholic priest be consulted to provide guidance.

(4) I consider food (nutrition) and water (hydration), even when provided by artificial means, always to be a natural and, in principle, ordinary and proportionate means of preserving life, not medical or therapeutic acts. I direct my attorney in fact to authorize and my health care providers to provide food and fluids orally, intravenously, by tube, or by other means

CONTINUED

to the full extent necessary both to preserve my life and to assure me the optimal health possible, unless or until the benefits of such nutrition and hydration are clearly outweighed by a definite danger or burden, or are useless in achieving their intended outcome.

(5) I reject in any situation any treatment that directly uses an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who is a product of an induced abortion.

(6) I reject in any situation any treatments that use an organ or tissue of another person obtained in a manner that directly causes, contributes to, or hastens that person's death.

(7) It is my intention that the instructions in this document are to be followed even if it is alleged that I have attempted suicide at some point after it is signed.

(8) I direct that medical treatment and health care be provided to me to preserve my life without discrimination based on my age, physical or mental disability, or the actual or anticipated "quality" of my life.

(9) I direct that my life not be ended by assisted suicide or euthanasia, the latter meaning an action or omission that would directly and intentionally cause my death.

B. PARTICULAR INSTRUCTIONS CONCERNING LIFE-PROLONGING TREATMENT

When I am in the final stages of a terminal illness or injury or when my death is imminent, I ask that I be informed of this so that I may prepare myself for death. Furthermore, I request (initial each item you request):

____ That I be attended by a Catholic priest and be provided the opportunity to receive the Sacraments of the Church (Reconciliation, Holy Eucharist and the Anointing of the Sick) if I am Catholic.

____ To the degree possible, that all reasonable steps be taken to allow me to see my family and to reconcile with anyone from whom I may have become estranged.

____ To the degree possible, that I be permitted to die at home or in a hospice that has the appearance of a home setting.

After reasonable efforts have been made to satisfy my requests as confirmed above, I direct the following:
(initial only ONE choice):

____ That the application of all life-prolonging procedures (including artificial respiration, cardiopulmonary resuscitation and invasive procedures) which would serve only to artificially prolong the dying process be withdrawn or withheld, and that I be permitted to die naturally with only the administration of medications and the performance of medical procedures deemed necessary to ensure my comfort and alleviate pain.

OR

____ That all treatments to prolong my life as long as reasonably possible within the limits of generally accepted heath care standards be continued.

OR

____ That I choose to provide no written guidelines and direct my attorney in fact to make end-of-life decisions based on my known values and wishes.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this Power of Attorney for Health Care shall be honored by my family and physician as the final expression of my legal right

CONTINUED

to refuse health care and my acceptance of the consequences of such refusal. In all cases, I direct that decisions about my medical treatment and health care be made in accordance with Catholic moral teachings.

C. ADDITIONAL HEALTH CARE INSTRUCTIONS FOR WOMEN

If I am pregnant, I direct that, regardless of my physical or mental condition, all medically indicated procedures, including medically assisted nutrition and hydration, be provided to sustain my life and the life of my unborn child until birth or at least until the child's viability is attained. No one is authorized to consent to any treatment or procedure for me whose sole immediate and directly intended effect is the termination of my pregnancy before the viability of my unborn child is attained.

I understand that I may morally accept or refuse operations, medications and forms of treatment that have as their direct purpose the cure of a serious pathological condition when these interventions cannot be safely postponed until the viability of my unborn child is attained, even if such interventions indirectly result in the death of my child. If I am determined to be incapable of providing consent for such interventions, I (initial ONE choice):

_____ Grant the authority to my attorney in fact to consent to or refuse such interventions.

_____ Do not grant the authority to my attorney in fact to consent to or refuse such interventions.

SECTION III: APPOINTMENT OF AN AGENT TO MAKE AN ANATOMICAL GIFT OR ORGAN, TISSUE OR EYE DONATION

THIS SECTION IS OPTIONAL: CROSS THROUGH THIS SECTION IF YOU DO NOT WANT TO APPOINT AN ATTORNEY IN FACT TO MAKE AN ANATOMICAL GIFT OR ANY ORGAN, TISSUE OR EYE DONATION FOR YOU.

1. Legal Authorization. Upon my certain death, I direct that an anatomical gift of all of my body or certain organ, tissue or eye donations shall be made in accordance with my directions below.
2. Appointment of attorney in fact (initial ONE choice):

_____ The same attorney in fact (and successor attorney in fact) named in SECTION I above.

OR

_____ I hereby appoint the following person as my attorney in fact to make such anatomical gift or organ, tissue or eye donation following my certain death:

Name of primary attorney in fact for this purpose(printed): _____

Address (printed): _____

Telephone: _____

3. Directions to attorney in fact [optional]: I give the following instructions regarding my anatomical gift or organ, tissue or eye donation:

_____

_____

4. No ovum or sperm shall be extracted — from my anatomical gift, from my organ or tissue donation, or as a tissue donation — for the purpose of creating an embryo.

CONTINUED

SECTION IV: AFFIRMATION AND RIGHT TO REVOKE

By signing below, I state that I am emotionally and mentally capable of making this Power of Attorney for Health Care and that I understand the purpose and effect of this document. I understand that I may revoke all or any part of this document at any time (i) with a signed document, dated and in writing; (ii) by physical cancellation or destruction of this Power of Attorney for Health Care by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.

Copies of this document carry the full force and authority as the original. The original of this document is in the possession of or can be found at [print name or specify location where original document can be found]:

SIGNATURE AND WITNESSES:

SIGNATURE OF PRINCIPAL DATE

The principal is at least 19 years of age and voluntarily dated and signed the foregoing Power of Attorney for Health Care in my presence, without any appearance of being under duress, undue influence or fraud.

WITNESS WITNESS

POWER OF ATTORNEY FOR HEALTH CARE SUPPLEMENT FOR MENTAL HEALTH CARE

PATIENT PROTEST TREATMENT OPTION (THIS SECTION IS OPTIONAL)

This Section includes my specific instructions about my health care if I am objecting to health care that my attorney in fact and my physician believe I need. (NEBRASKA LAW CLEARLY STATES THAT NOTHING IN THIS SECTION CAN BE USED TO AUTHORIZE ANYONE TO MAKE ANY DECISION THAT INVOLVES THE WITHDRAWAL OR WITHHOLDING OF LIFE-PROLONGING TREATMENT.)

To complete this section, you will need the signature of your physician or clinical psychologist certifying that you are capable of making an informed decision and that you understand the consequences of this provision at the time you execute (sign) the Power of Attorney for Health Care. This is the only Section in the Power of Attorney for Health Care that requires a signature from a physician or a licensed clinical psychologist. A physician's signature is not required for any other portion of this document; all other portions of this Power of Attorney for Health Care are in full effect with or without a physician's signature.

CONTINUED

SPECIAL POWERS OF MY ATTORNEY IN FACT TO AUTHORIZE HEALTH CARE OVER MY OBJECTION

I, (print name) _____ give my attorney in fact the power to authorize my physicians to provide me the specific types of medically necessary treatment and health care authorized below even over my protest (initial each item you authorize):

____ To authorize my admission to a health care facility for the treatment of mental illness as permitted by law, even if I object.

____ To authorize other health care that is permitted by law and that my attorney in fact and my physician believe I need, even if I object. This would include any type of health care unless I have indicated otherwise by my specific instructions written in this document, in my Power of Attorney for Health Care, or in the space below.

I do not authorize the following specific types of health care: _____

ADDITIONAL MENTAL HEALTH CARE INSTRUCTIONS — IF ANY

If you want to give additional instructions about your mental health care, you may do so here. You may use this section to direct your mental health care even if you do not have an attorney in fact. If you do not give specific instructions, your mental health care will be based, to the extent allowed by law, on your wishes and values if known, or otherwise on your best interest.

A. I specifically direct that I receive the following mental health care if it is medically appropriate:

B. I specifically direct that I not receive the following mental health care:

TO GIVE YOUR ATTORNEY IN FACT ANY OF THE POWERS SET FORTH ABOVE, YOUR PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST MUST SIGN THE STATEMENT BELOW.

I am a physician or licensed clinical psychologist familiar with the person who has made this Power of Attorney for Health Care Supplement for Mental Health Care. I attest that he or she is presently capable of making an informed decision and that he or she understands the consequences of the special powers given to his/her attorney in fact by this Supplement.

PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST (PRINTED NAME AND ADDRESS)

SIGNATURE OF PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST DATE

AFFIRMATION AND RIGHT TO REVOKE: By signing below, I affirm that I understand this Power of Attorney for Health Care Supplement for Mental Health Care and that I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

SIGNATURE OF PRINCIPAL DATE