Great Plains Health
601 West Leota Street
North Platte, NE 69101
308.568.8000

Patient Label

POWER OF ATTORNEY FOR HEALTH CARE

Name: _____ DOB: _____ Last 4 SSN: _____

I, the individual whose information appears above, appoint as my attorney in fact for health care decisions the individual whose information appears under "Attorney in Fact for Health Care". I also appoint as my successor attorney in fact for health care the individual whose information appears under "Successor Attorney in Fact for Health Care".

Attorney in Fact for Health Care
Name
Address
City/State/Zip
Phone Number

Successor Attorney in Fact for Health Care
Name
Address
City/State/Zip
Phone Number

_____ [Initial] 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 included in this document and understand the consequences of executing a power of attorney for health care.

_____ [Initial] I direct that my attorney-in-fact comply with the following instructions or limitations, including those instructions on life-sustaining treatment and artificially administered nutrition and hydration:

_____ [Initial] I direct my attorney-in-fact to authorize the withholding or withdrawal of any mechanical procedure, treatment or intervention that uses mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function which would, when applied to me, serve only to prolong my dying process or persistent vegetative state.

- 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 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 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 before Notary Date / Time

STATE OF NEBRASKA

COUNTY OF LINCOLN

Subscribed and sworn to before me, a notary public in and for said county, this____day of _____, 20____.

_____, Notary Public

My commission expires _____

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