

5307 Allum Rd., Unit B  
Houston TX 77045  
MedicalDirectives.net  
T/F: 866 -300-7388

Thank you for downloading the PDF-fillable form for your Medical Directive, Advance Medical Directive, or Medical Power of Attorney. The process is very straightforward:

1. Choose the subscription type you want and pay online. We use paypal for all credit card processing and NEVER store your Credit Card Information.
2. Download the form to your computer.
3. Fill it out on your computer and print it.
4. Take the filled-form to your favorite notary (or your witnesses) and have it notarized or witnessed.
5. Fax your paperwork to 866-300-7388. If you want to email it instead, please SCAN all to PDF utilizing 200 DPI scan settings, making 1 PDF file, and email to [forms@medicaldirectives.net](mailto:forms@medicaldirectives.net)
6. Your Retrieval Card is emailed out to you within 24 hours of receiving your medical directive. If you lose it or need another one, you can generate one easily on our web portal .

Here is the form for the state you selected. Please do not fax back any instruction sheets. We do not require a coversheet when you fax.

# Nebraska Living Will Declaration

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If I should lapse into a persistent vegetative state or 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 the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

Other directions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed this \_\_\_\_\_ day of \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

The declarant voluntarily signed this writing in my presence.

Witness \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

**Or**

The declarant voluntarily signed this writing in my presence.

\_\_\_\_\_

Notary Public

**Nebraska**  
**Power of Attorney for Health Care**

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1. 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.

2. I direct that my attorney-in-fact comply with the following instructions or limitations:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

4. 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.**

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(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, and 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 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 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.

\_\_\_\_\_  
Notary Public