

LIVING WILL DECLARATION

If I should lapse into a 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 by 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 instructions: _____

THIS MUST BE WITNESSED BY TWO WITNESSES OR A NOTARY PUBLIC.

The declarant voluntarily signed this writing in my presence; we are not the principal's spouse, parent, child, grandchild, sibling, presumptive heir, attending physician, or employee of life or health insurance provider.

Witness _____

Address _____

Witness _____

Address _____

We declare that the principal is personally known to us and that (he/she) signed (his/her) signature on this power of attorney for health care in our presence, that (he/she) 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.

STATE OF NEBRASKA

COUNTY OF Phelps

On this _____ day of _____, 20____ before me, a notary public in and for Phelps 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 Holdrege, Nebraska in such county the day and year last above written.

Notary Public