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# How to Complete Your Nevada Advance Health-Care Directive

Name a Health Care Agent and State Your Wishes (NRS 162A.855)

**INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR NEVADA ADVANCE HEALTH-CARE DIRECTIVE.**

**About this form.** This is Nevada's official advance health-care directive, in effect since January 1, 2024. It lets you name an **agent** to make health care decisions if you cannot, state your wishes about life-sustaining treatment and your priorities, give optional special powers, nominate a guardian, and make an organ donation decision. You may complete all or any part of it.

1. **Name your agent and an alternate (Part 1)**
   Choose people you trust and talk with them first. You may also limit your agent's authority.
2. **State your treatment wishes and priorities (Part 2)**
   Mark or initial the choices that fit your wishes about life-sustaining treatment, tube feeding, and pain care, and what matters most to you.
3. **Optional powers, guidance, and guardian (Part 3)**
   Mark any special powers you want to give, whether your agent may see your health information at any time, and who should be your guardian if needed.
4. **Make your organ donation choice (Part 4)**
   Mark whether you wish to donate and for what purposes, or leave it blank.
5. **Sign before a notary or two witnesses (Part 5)**
   Nevada law allows either. Your agent cannot be a witness, and nursing home staff cannot witness for a resident. Many hospitals prefer notarization. Do **not** sign ahead of time. **We come to your home, hospital, or care facility.**
6. **Share copies**
   Give copies to your agent, alternate agent, doctor, and hospital. You may also register it with Nevada's advance directive registry.

## Good to Know

- Signing a new health care power of attorney automatically revokes any earlier one (NRS 162A.820).
- Directives signed before 2024 on Nevada's older form generally remain valid. You may update to this form at any time.
- For financial matters, use the Nevada Statutory Form Power of Attorney.

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SCAN TO BOOK

**Questions about this document? Talk to an attorney.** Gavrilov & Brooks Law Firm has attorneys licensed in Nevada, California, and other states. Phone and video consultations are available. **(916) 504-0529** · **www.gavrilovlaw.com**

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**YOUR FORM BEGINS ON THE NEXT PAGE**

# ADVANCE HEALTH-CARE DIRECTIVE

(Nevada Revised Statutes Section 162A.855)

## HOW YOU USE THIS FORM

You can use this form if you wish to name someone to make health care decisions for you in case you cannot make them for yourself. This is called giving the person you name a power of attorney for health care. The person you name is called your agent.

You can also use this form to state your wishes, preferences and goals for health care, and to say if you want to be an organ donor after you die.

## YOUR NAME AND DATE OF BIRTH

Name _____ Date of birth _____

## PART 1: NAMING AN AGENT

*This part lets you name someone else to make health care decisions for you. You may leave any item blank.*

**(1) NAMING AN AGENT:** I want the following person to make health care decisions for me if I cannot make decisions for myself:

Name

Optional contact information (It is helpful to include information such as the person's address, phone number and email address.):

**(2) NAMING AN ALTERNATE AGENT:** I want the following person to make health care decisions for me if I cannot and my agent is not willing, able or reasonably available to make them for me:

Name

Optional contact information (It is helpful to include information such as the person's address, phone number and email address.):

**(3) LIMITING YOUR AGENT'S AUTHORITY:** I give my agent the power to make all health care decisions for me if I cannot make those decisions for myself, except for the following:

*(If you do not add any limitations here, your agent will be able make all health care decisions that an agent is permitted to make under state law.)*

## PART 2: HEALTH CARE INSTRUCTION

*This part lets you state your priorities for health care and types of health care you do and do not want.*

### (1) INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT

*This section gives you the opportunity to say how you want your agent to act while making decisions for you. You may mark or initial each item. You may also leave any item blank.*



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Medical treatment needed to keep me alive but not needed for comfort or any other purpose should (mark all that apply):

- ☐ Always be given to me.
- ☐ Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
- ☐ Not be given to me if I am unconscious and I am not expected to be conscious again.
- ☐ Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
- ☐ Other (write what you want or do not want):

If I cannot swallow and staying alive requires me to get liquid or food through a tube or other means for the rest of my life, liquid or food should (mark all that apply):

- ☐ Always be given to me.
- ☐ Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
- ☐ Not be given to me if I am unconscious and I am not expected to be conscious again.
- ☐ Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
- ☐ Other (write what you want or do not want):

If I am in significant pain, care that will keep me comfortable but is likely to shorten my life should (mark all that apply):

- ☐ Always be given to me.
- ☐ Never be given to me.
- ☐ Be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
- ☐ Be given to me if I am unconscious and I am not expected to be conscious again.
- ☐ Be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself and recognizing family and friends.
- ☐ Other (write what you want or do not want):

**(2) INSTRUCTION ABOUT PRIORITIES**

*You can use this section to indicate what is important to you, and what is not important to you. This information can help your agent make decisions for you if you cannot. It also helps others understand your preferences.*

*You may mark or initial each item. You also may leave any item blank.*

Staying alive as long as possible even if I have substantial physical limitations is:

☐ very important ☐ somewhat important ☐ not important



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Staying alive as long as possible even if I have substantial mental limitations is:

☐ very important ☐ somewhat important ☐ not important

Being free from significant pain is:

☐ very important ☐ somewhat important ☐ not important

Being independent is:

☐ very important ☐ somewhat important ☐ not important

Having my agent talk with my family before making decisions about my care is:

☐ very important ☐ somewhat important ☐ not important

Having my agent talk with my friends before making decisions about my care is:

☐ very important ☐ somewhat important ☐ not important

### (3) OTHER INSTRUCTIONS

*You can use this section to provide any other information about your goals, values and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.*

## PART 3: OPTIONAL SPECIAL POWERS AND GUIDANCE

*This part allows you to give your agent additional powers and to provide your agent with more guidance about your wishes. You may mark or initial each item. You also may leave any item blank.*

### (1) OPTIONAL SPECIAL POWERS

My agent can do the following things ONLY if I have initialed or marked them below:

☐ Admit me as a voluntary patient to a facility for mental health treatment for up to 7 days, 14 days or 30 days (circle one).
(If I do not mark or initial this, my agent MAY NOT admit me as a voluntary patient to this type of facility.)

☐ Place me in a nursing home for more than 100 days even if my needs can be met somewhere else, I am not terminally ill and I object.
(If I do not mark or initial this, my agent MAY NOT do this.)

### (2) ACCESS TO MY HEALTH INFORMATION

My agent may obtain, examine and share information about my health needs and health care if I am not able to make decisions for myself. If I initial or mark below, my agent may also do this at any time he or she thinks it will help me.

☐ I give my agent permission to obtain, examine and share information about my health needs and health care whenever he or she thinks it will help me.



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### (3) GUIDANCE FOR MY AGENT

The instructions I have stated in this document should guide my agent in making decisions for me (initial or mark one of the below items to tell your agent more about how to use these instructions):

- ☐ I give my agent permission to be flexible in applying these instructions if he or she thinks it would be in my best interest based on what they know about me.
- ☐ I want my agent to follow these instructions exactly as written if possible, even if he or she thinks something else is better.

### (4) NOMINATION OF GUARDIAN

Here you can say who you would want as your guardian if you need one. A guardian is a person appointed by a court to make decisions for someone who cannot make decisions. Filling this out does NOT mean you want or need a guardian right now.

If a court appoints a guardian to make personal decisions for me, I want the court to choose:

- ☐ My agent named in this form. If my agent cannot be a guardian, I want my alternate agent named in this form.
- ☐ Other (write who you would want and their contact information):

## PART 4: ORGAN DONATION

*This part allows you to donate your organs when you die. You may mark or initial each item. You also may leave any item blank.*

Even if it requires maintaining treatments that could prolong my dying process and might be in conflict with other instructions I have put in this form, upon my death:

- ☐ I donate my organs, tissues and other body parts, except for those listed below (list any body parts you do not want to donate):
- ☐ I do not want my organs, tissues or body parts donated to anybody for any reason.

Organs, tissues or body parts that I donate may be used for:

☐ transplant ☐ therapy ☐ research ☐ education ☐ all of the above



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## PART 5: SIGNATURES REQUIRED ON THIS FORM

### YOUR SIGNATURE

Sign your name: _____

Today's date: _____

### SIGNATURE OF WITNESSES

You need two witnesses if you are using this form to name an agent. The witnesses must be adults and cannot be the person you are naming as agent. If you live in a nursing home, the witness cannot be an employee of the home or someone who owns or runs the home.

Witness name: _____

Witness signature: _____

Date witness signed: _____

*(Only sign as a witness if you think that the person signing above is doing it voluntarily.)*

Witness name: _____

Witness signature: _____

Date witness signed: _____

*(Only sign as a witness if you think that the person signing above is doing it voluntarily.)*

## PART 6: INFORMATION FOR AGENTS

(1) If this form names you as an agent, you can make decisions about health care for the person who named you when they cannot make their own.
(2) If you make a decision for the person, follow any instructions the person gave, including any in this form.
(3) If you make a decision for the person and you don't know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences and goals if you know them or can learn them. Some of those preferences might be in this form. You should also consider any behaviors or communications from the person that indicate what they currently want.
(4) If this form names you as an agent, you can also get and share the individual's health information. But unless the person has said so in this form, you can only get or share this information when the person cannot make their own decisions about their health care.



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# CERTIFICATE OF ACKNOWLEDGMENT

(Nevada Revised Statutes Section 240.166)

*Under NRS 162A.790, the principal's signature must be acknowledged before a notary public or witnessed by two adult witnesses. Many hospitals and out-of-state providers prefer a notarized directive; you may use both.*

State of Nevada )

County of _____ )

This instrument was acknowledged before me on _____ by
(date)

_____ .
(name(s) of person(s))

_____
(Signature of notarial officer)

_____
(Title and rank (optional))

(Seal, if any)



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