

DIRECTIVE TO PHYSICIANS

Date _____

I, _____, being of sound mind, intentionally and voluntarily declare:

1. If at any time I am in a terminal condition and become comatose or am otherwise rendered incapable of communicating with my attending physician, and my death is imminent because of an incurable disease, illness or injury, I direct that life sustaining procedures be withheld or withdrawn, and that I be permitted to die naturally.
2. It is my intention that this directive be honored by my family and attending physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of my refusal.
3. If I have been found to be pregnant, and that fact is known to my physician, this directive is void during the course of my pregnancy. I understand the full import of this directive, and I am emotionally and mentally competent to execute it. (This section of the declaration form should be omitted for male declarants.)

Print Name _____ Signature _____

Address _____
Street Apt. City State Zip

This Directive must be:

- (1) signed by at least two qualified witnesses who are personally known to you; or,
- (2) acknowledged before a Notary Public.

The declarant has been personally known to me and I believe

_____ to be of sound mind.

WITNESS: Signature _____

Print Name _____

Residing at _____

City _____

State Zip

WITNESS: Signature _____

Print Name _____

Residing at _____

City _____

State Zip

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC (You may use Acknowledgement before a Notary Public instead of the Statement of Witnesses.)

STATE OF NEVADA)

) SS.

CARSON CITY)

On this _____

Date

Name

personally appeared before me, whose identity I verified on the

basis of _____, to be the person who

Form of Identification

signed the above document.

Notary Public

Residing at _____

Note: I request that this declaration or a copy thereof be placed in medical record with my physician and a notation made of its presence and the date of its execution.

Initial

We advise you to keep this original document in an accessible place. Your attorney-in-fact and your providers of health care should have a copy.



DECLARATION

If I should 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 NRS 449.540 to 449.690, inclusive and section 2 to 12, inclusive, of this act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the above statement, place your INITIALS in the space provided: ()

I direct my physician not to withhold or withdraw artificial nutrition and hydration by way of gastrointestinal tract if such withholding or withdrawal would result in my death by starvation or dehydration.

If the above statement reflects your desires, place your INITIALS in the space provided: ()

Signed this _____ day of _____, 20 _____

Patient Name _____ Signature: _____

Address: _____
Street Apt City State Zip

This Declaration must be:

- (1) signed by at least two qualified witnesses who are personally known to you; or,
- (2) acknowledged before a Notary Public

The Declarant voluntarily signed this writing in my presence.

The declarant has been personally known to me and I believe

to be of sound mind.

WITNESS: Signature _____

Print Name _____

Residing at _____

Street

City _____

State Zip

WITNESS: Signature _____

Print Name _____

Residing at _____

Street

City _____

State Zip

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY
PUBLIC (You may use Acknowledgement before a Notary
Public instead of the Statement of Witnesses.)
STATE OF NEVADA)

) SS.

CARSON CITY)

On this _____
Date Name

personally appeared before me, whose identity I verified on the

basis of _____, to be the person who

Form of Identification

signed the above document.

Notary Public

Residing at _____

