

# **SUGGESTIONS FOR PREPARING WILL TO LIVE DURABLE POWER OF ATTORNEY**

*(Please read the document itself before reading this.  
It will help you better understand the suggestions.)*

**YOU ARE NOT REQUIRED TO FILL OUT ANY PART OF THIS "WILL TO LIVE" OR ANY OTHER DOCUMENT SUCH AS A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. NO ONE MAY FORCE YOU TO SIGN THIS DOCUMENT OR ANY OTHER OF ITS KIND.**

The Will to Live form starts from the principle that the presumption should be for life. If you sign it without writing any "SPECIAL CONDITIONS," you are giving directions to your health care provider(s) and health care agent<sup>1</sup> to do their best to preserve your life.

Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

If you wish to refuse some specific medical treatment, the Will to Live form provides space to do so ("SPECIAL CONDITIONS"). You may make special conditions for your treatment when your death is imminent, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably terminally ill, meaning you will live no more than three months even if given all available medical treatment. There is also space for you to write down special conditions for circumstances you describe yourself.

The important thing for you to remember if you choose to fill out any part of the "SPECIAL CONDITIONS" sections of the Will to Live is that you must be very specific in listing what treatments you do not want. Some examples of how to be specific will be given shortly, or you may ask your physician what types of treatment might be expected in your specific case.

Why is it important to be specific? Because, given the pro-euthanasia views widespread in society and particularly among many (not all) health care providers, there is great danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

Many in the medical profession as well as in the courts are now so committed to the quality of life ethic that they take as a given that patients with severe disabilities are better off dead and would prefer not to receive either life-saving measures or nutrition and hydration. So pervasive is this "consensus" that it is accurate to say that in practice it is no longer true that the "presumption is

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<sup>1</sup> Some states use the terms "attorney in fact," "surrogate," "designee," and "representative" instead of "agent." They are synonymous for purposes of these suggestions.

for life" but rather for death. In other words, instead of assuming that a now incompetent patient would want to receive treatment and care in the absence of clear evidence to the contrary, the assumption has virtually become that since any "reasonable" person would want to exercise a "right to die," treatment and care should be withheld or withdrawn unless there is evidence to the contrary. The Will to Live is intended to maximize the chance of providing that evidence.

It is important to remember that you are writing a legal document, not holding a conversation, and not writing a moral textbook. The language you or a religious or moral leader might use in discussing what is and is not moral to refuse is, from a legal standpoint, often much too vague. Therefore, it is subject to misunderstanding or deliberate abuse.

The person you appoint as your health care agent may understand general terms in the same way you do. But remember that the person you appoint may die, or become incapacitated, or simply be unavailable when decisions must be made about your health care. If any of these happens, a court might appoint someone else you don't know in that person's place. Also remember that since the agent has to follow the instructions you write in this form, a health care provider could try to persuade a court that the agent isn't really following your wishes. A court could overrule your agent's insistence on treatment in cases in which the court interprets any vague language you put in your "Will to Live" less protectively than you meant it.

So, for example, do not simply say you don't want "extraordinary treatment." Whatever the value of that language in moral discussions, there is so much debate over what it means legally that it could be interpreted very broadly by a doctor or a court. For instance, it might be interpreted to require starving you to death when you have a disability, even if you are in no danger of death if you are fed.

For the same reason, do not use language rejecting treatment which has a phrase like "excessive pain, expense or other excessive burden." Doctors and courts may have a very different definition of what is "excessive" or a "burden" than you do. Do not use language that rejects treatment that "does not offer a reasonable hope of benefit." "Benefit" is a legally vague term. If you had a significant disability, a health care provider or court might think you would want no medical treatment at all, since many doctors and judges unfortunately believe there is no "benefit" to life with a severe disability.

What sort of language is specific enough if you wish to write exclusions? Here are some examples of things you might--or might not--want to list under one or more of the "Special Conditions" described on the form. Remember that any of these will prevent treatment ONLY under the circumstances--such as when death is imminent--described in the "Special Condition" you list it under. (The examples are not meant to be all inclusive--just samples of the type of thing you might want to write.)

"Cardiopulmonary resuscitation (CPR)." (If you would like CPR in some but not all circumstances when you are terminally ill, you should try to be still more specific: for example, you might write "CPR if cardiopulmonary arrest has been caused by my terminal illness or a complication of it." This would mean that you would still get CPR if, for example, you were the victim of smoke inhalation in a fire.) "Organ transplants." (Again, you could be still more specific,

rejecting, for example, just a "heart transplant.")

"Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer."

"A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me."

### **Pain Relief**

Under the "General Presumption for Life," of your Will to Live, you will be given medication necessary to control any pain you may have "as long as the medication is not used in order to cause my death." This means that you may be given pain medication that has the secondary, but unintended, effect of shortening your life. If this is not your wish, you may want to write something like one of the following under the third set of "Special Conditions" (the section for conditions you describe yourself):

"I would like medication to relieve my pain but only to the extent the medication would not seriously threaten to shorten my life." OR

"I would like medication to relieve my pain but only to the extent it is known, to a reasonable medical certainty, that it will not shorten my life."

Think carefully about any special conditions you decide to write in your "Will to Live." You may want to show them to your intended agent and a couple of other people to see if they find them clear and if they mean the same thing to them as they mean to you. Remember that how carefully you write may literally be a matter of life or death--your own.

**AFTER WRITING DOWN YOUR SPECIAL CONDITIONS, IF ANY, YOU SHOULD MARK OUT THE REST OF THE BLANK LINES LEFT ON THE FORM FOR THEM (JUST AS YOU DO AFTER WRITING OUT THE AMOUNT ON A CHECK) TO PREVENT ANY DANGER THAT SOMEBODY OTHER THAN YOU COULD WRITE IN SOMETHING ELSE.**

**IT IS WISE TO REVIEW YOUR WILL TO LIVE PERIODICALLY TO ENSURE THAT IT STILL GIVES THE DIRECTIONS YOU WANT FOLLOWED.**

Robert Powell Center for Medical Ethics  
National Right to Life  
[www.nrlc.org](http://www.nrlc.org) ~ (202) 378-8862

# How to use the Nevada Will to Live Form

## Suggestions and Requirements:

1. This document allows you to designate an attorney-in-fact for health care- someone, who does not have to be a lawyer, who will make health care decisions for you whenever you are unable to make them for yourself. It also allows you to give instructions concerning medical treatment decisions that the attorney-in-fact must follow. Any adult may designate an attorney-in-fact for health care through this document.
2. Under Nevada law, your attorney-in-fact will not have the authority to authorize your commitment or placement in a facility for treatment of mental illness, convulsive treatment, psychosurgery, sterilization, or abortion.
3. Unless the person you wish to name as your attorney-in-fact for health care is your spouse, legal guardian, or next of kin, your attorney-in-fact cannot be your health care provider, an employee of your health care provider or an operator or employee of a health care facility.
4. It is helpful to designate successor attorneys in fact for health care, to take over if your first choice is unable to serve. There is space on the form for you to designate two successor attorneys in fact.
5. Nevada law requires that this form be used, even though the statements on page 5 in Part 6, (“Statement of Desires”) of the form either duplicate or are inconsistent with the “Will to Live” language beginning on page 3 in part 4 (“Special Provisions and Limitations”). In order to ensure that the Will to Live language controls, these sentences have been added at the bottom of Part 6: “Some of the 5 statements above are inconsistent with my instructions in paragraph 4 while others are similar to those instructions. They are not initialed because they should not be necessary in light of those instructions, not necessarily because I disagree with all of them.”

**\*Because initialing statements in Part 6 could lead to interpretations inconsistent with the Will to Live language, if you wish to avoid confusion you should not initial any of the statements in Part 6. Even though some of them may seem to be compatible with what you have directed in the Will to Live language in Part 4, initialing them is not necessary and could lead to misunderstanding about your intentions.**

6. The authority of your attorney-in-fact takes effect only when you no longer have the capacity to give informed consent with respect to your own health care decisions.
7. You must do one of the following to properly designate an attorney-in-fact for health care through this document. EITHER

A.) Sign and date this document in the presence of two adult witnesses who know

you personally. The two witnesses must sign and date the document.

OR:

B.) Have it notarized before a notary public.

8. If you use witnesses, the two witnesses must be adults. Your witnesses cannot include your attorney-in-fact, your health care provider or an employee of your health care provider, or an operator or employee of a health care facility. If you use witnesses and not a notary public, at least one of the witnesses must also sign the declaration included at the end of the form. The witness who signs this declaration cannot be related to you by blood, marriage, or adoption, nor be entitled to inherit anything from you under your will or state law.
9. The document will remain in effect until you revoke (cancel) it. You can revoke the appointment of the person you designated in this document as your attorney-in-fact for health care by notifying that person of the revocation either orally or in writing. You can also revoke the authority granted to your attorney-in-fact by notifying your treating physician, hospital, or other health care provider either orally or in writing. This document revokes any prior durable power of attorney for health care, and any durable power of attorney for health care you sign later will revoke this one. If, in this durable power of attorney for health care document, you have designated your spouse as your attorney-in-fact, that designation will be automatically revoked if your marriage to that spouse is dissolved.
10. You should tell your doctor about this document. You should also ask your doctor to keep a copy of this document as part of your medical health record. Give copies of the signed original to your health care attorney-in-fact, family members, and anyone else you think appropriate. Keep the original document in a safe place that will be easily accessible to others in case of an emergency and tell someone where it is.
11. This type of document has been authorized by the Nevada Durable Power of Attorney for Health Care Act, Nev. Rev. Stat. Ann. § 449.800 to § 449.860.
12. You should periodically review your document to be sure it complies with your wishes. Before making any changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting [www.nrlc.org](http://www.nrlc.org) (Click on “Will to Live”) or an attorney to determine if this form can still be used.
13. If you have any questions about this document or want assistance filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit:

[www.nrlc.org](http://www.nrlc.org) and click on “Will to Live”

Form prepared 2001  
Clerical changes made 02/09

## **Nevada Durable Power of Attorney for Health Care Decisions with Will to Live Language**

### **Warning to Person Executing This Document**

This is an important legal document. It creates a durable power of attorney for health care. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements you do not desire.
2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interest.
3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
4. Unless you specify a shorter period in this document, this power will exist indefinitely from the date you execute this document, and, if you are unable to make health care decisions for yourself, the power will continue to exist until the time when you are able to make health care decisions for yourself.
5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.
8. The person designated in this document to make health care decisions for you has the

right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior durable power of attorney for health care.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTH CARE AGENT

I, \_\_\_\_\_ do hereby designate and appoint:  
(Insert your name)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

as my attorney-in-fact to make health care decisions for me as authorized in this document. *(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian, or the person most closely related to you by blood, none of the following may be designated as your attorney -in-fact: (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3) an operator of a health care facility, or (4) an employee of an operator of a health care facility)*

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

*(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)*

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

**GENERAL PRESUMPTION FOR LIFE**

I direct my health care provider(s) and health care attorney-in -fact(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney- in- fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an



unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy. I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care attorney-in-fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney-in-fact, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

**WHEN MY DEATH IS IMMINENT**

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**WHEN I AM TERMINALLY ILL**

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**C. OTHER SPECIAL CONDITIONS:**

**(Be as specific as possible; SEE SUGGESTIONS.):**

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(Cross off any remaining blank lines.)

**IF I AM PREGNANT**

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney-in-fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

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Signature of Declarant

5. DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this power of attorney end on the following date: \_\_\_\_\_.

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

(If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures. [\_\_\_\_\_]
2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and sections 2 to 12, inclusive, of chapter 258, Statutes of Nevada 1991, if this subparagraph is initialed.) [\_\_\_\_\_]
3. If I have an incurable or terminal condition or illness and no reasonable hope of recovery or survival, I desire that life sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.540 to 449.690, inclusive, and sections 2 to 12, inclusive, of chapter 258, Statutes of Nevada, 1991, if this subparagraph is initialed. [\_\_\_\_\_]
4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld. [\_\_\_\_\_]
5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.[\_\_\_\_\_]

*(If you wish to change your answer you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)*

Other or Additional Statements of Desires:

Some of the 5 statements above are inconsistent with my instructions in paragraph 4, while others are similar to those instructions. They are not initialed because they should not be necessary in light of those instructions, not necessarily because I disagree with all of them.

7. DESIGNATION OF ALTERNATIVE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following person to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-Fact

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

B. Second Alternative Attorney-in-Fact

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on \_\_\_\_\_ (date)

at \_\_\_\_\_,

(city)

(state)

Signature \_\_\_\_\_

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of Nevada

County of \_\_\_\_\_ )  
 ) ss.  
 )

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year \_\_\_\_\_, before me, \_\_\_\_\_ (here insert name of notary public) personally appeared \_\_\_\_\_ (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

\_\_\_\_\_  
(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact, (2) a provider of health care, (3) an employee of a provider of health care, (4) the operator of a health care facility, (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses must sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an

employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

(At least one of the above witnesses must also sign the following declaration.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Address: \_\_\_\_\_

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

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.