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ASSEMBLY BILL NO. 128—COMMITTEE ON JUDICIARY

(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON SENIOR  
CITIZENS, VETERANS AND ADULTS WITH SPECIAL NEEDS)

FEBRUARY 6, 2015

Referred to Committee on Judiciary

SUMMARY—Creates a power of attorney for health care decisions  
for adults with intellectual disabilities.  
(BDR 13-418)

FISCAL NOTE: Effect on Local Government: No.  
Effect on the State: No.

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EXPLANATION – Matter in *bolded italics* is new; matter between brackets ~~omitted material~~ is material to be omitted.

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AN ACT relating to powers of attorney; creating a power of  
attorney for health care decisions for adults with  
intellectual disabilities; and providing other matters  
properly relating thereto.

**Legislative Counsel’s Digest:**

1 Existing law sets forth provisions governing durable powers of attorney for  
2 health care decisions. (NRS 162A.700-162A.860) Existing law specifically  
3 provides an example of a form for a power of attorney for health care. (NRS  
4 162A.860) **Section 3** of this bill provides an example of a form for a power of  
5 attorney for health care for adults with intellectual disabilities.

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THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN  
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 **Section 1.** Chapter 162A of NRS is hereby amended by  
2 adding thereto the provisions set forth as sections 2 and 3 of this act.

3 **Sec. 2.** *“Intellectual disability” means significantly*  
4 *subaverage general intellectual functioning existing concurrently*  
5 *with deficits in adaptive behavior and manifested during the*  
6 *developmental period.*



1     **Sec. 3.** *The form of a power of attorney for health care for*  
2 *an adult with an intellectual disability may be substantially in the*  
3 *following form, and must be witnessed or executed in the same*  
4 *manner as the following form:*

5  
6                                   **DURABLE POWER OF ATTORNEY**  
7                                   **FOR HEALTH CARE DECISIONS**  
8

9             *My name is ..... (insert your name) and my*  
10 *address is ..... (insert your address). I would like to*  
11 *designate ..... (insert the name of the person you*  
12 *wish to designate as your agent to make health care*  
13 *decisions for you) as my agent to make health care decisions*  
14 *for me if I am sick or hurt and need to see a doctor or go to*  
15 *the hospital. I understand what this means.*

16             *If I am sick or hurt, my agent should take me to the*  
17 *doctor. If my agent is not with me when I become sick or*  
18 *hurt, please contact my agent and ask him or her to come to*  
19 *the doctor's office. I would like the doctor to speak with my*  
20 *agent about my sickness or injury and whether I need any*  
21 *medicine or other treatment. After my agent speaks with the*  
22 *doctor, I would like my agent to decide what care or*  
23 *treatment I should receive and speak with me about that*  
24 *care or treatment.*

25             *If I am very sick or hurt, I may need to go to the hospital.*  
26 *I would like my agent to decide if I need to go to the*  
27 *hospital. If I go to the hospital, I would like the people who*  
28 *work at the hospital to try very hard to care for me. If I am*  
29 *able to communicate, I would like the doctor at the hospital*  
30 *to speak with me about what care or treatment I should*  
31 *receive, even if I am unable to understand what is being*  
32 *said about me. I would also like the doctor at the hospital to*  
33 *speak with my agent about what care or treatment I should*  
34 *receive. After my agent speaks with the doctor, I would like*  
35 *my agent to decide what care or treatment I should receive*  
36 *and, if I am able to communicate, speak with me about that*  
37 *care or treatment.*

38             *I would like my agent to decide if I need to see a dentist*  
39 *and make decisions about what care or treatment I should*  
40 *receive from the dentist.*

41             *I would also like my agent to be able to see and have*  
42 *copies of all my medical records. If my agent requests to see*  
43 *or have copies of my medical records, please allow him or*  
44 *her to see or have copies of the records.*



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*If my agent is unable to make health care decisions for me, then I designate ..... (insert the name of another person you wish to designate as your alternative agent to make health care decisions for you) as my agent to make health care decisions for me as authorized in this document.*

**(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)

**AGENT SIGNATURE**

*As agent for ..... (insert name of principal), I agree that a physician, health care facility or other provider of health care, acting in good faith, may rely on this power of attorney for health care and the signatures herein, and I understand that pursuant to NRS 162A.815, a physician, health care facility or other provider of health care that in good faith accepts an acknowledged power of attorney for health care is not subject to civil or criminal liability or discipline for unprofessional conduct for giving effect to a declaration contained within the power of attorney for health care or for following the direction of an agent named in the power of attorney for health care.*

*Signature: ..... Residence Address:.....  
Print Name: .....  
Date:.....*

**(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 YOU KNOW 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            }*  
*}ss.*  
*County of.....          }*

*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)**

**STATEMENT OF WITNESSES**

*(If you choose to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. The following people cannot be used as a witness: (1) a person you designate as the agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; or (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 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 agent 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 health care facility or an employee of an operator of a health care facility.*



\* A B 1 2 8 \*

1            *Signature:* .....            *Residence Address:*.....  
 2            *Print Name:* .....            .....

3            *Date:*.....            .....

4

5            *Signature:* .....            *Residence Address:*.....  
 6            *Print Name:* .....            .....

7            *Date:*.....            .....

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9            **(AT LEAST ONE OF THE ABOVE WITNESSES**  
 10           **MUST ALSO SIGN THE FOLLOWING DECLARATION.)**

11

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

17

18            *Signature:* .....  
 19            *Signature:* .....

20

21            *Names:* .....            *Address:* .....

22            *Print Name:* .....            .....

23            *Date:*.....            .....

24

25            ***COPIES: You should retain an executed copy of this***  
 26            ***document and give one to your agent. The power of attorney***  
 27            ***should be available so a copy may be given to your providers***  
 28            ***of health care.***

29            **Sec. 4.** NRS 162A.700 is hereby amended to read as follows:  
 30            162A.700 NRS 162A.700 to ~~162A.860,~~ **162A.850**, inclusive,  
 31            **and section 2 of this act** apply to any power of attorney containing  
 32            the authority to make health care decisions.

33            **Sec. 5.** NRS 162A.710 is hereby amended to read as follows:  
 34            162A.710 As used in NRS 162A.700 to 162A.860, inclusive,  
 35            **and sections 2 and 3 of this act**, unless the context otherwise  
 36            requires, the words and terms defined in NRS 162A.720 to  
 37            162A.780, inclusive, **and section 2 of this act** have the meanings  
 38            ascribed to them in those sections.

39            **Sec. 6.** NRS 162A.860 is hereby amended to read as follows:  
 40            162A.860 ~~The~~ **Except as otherwise provided in section 3 of**  
 41            **this act, the** form of a power of attorney for health care may be  
 42            substantially in the following form, and must be witnessed or  
 43            executed in the same manner as the following form:



DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE DECISIONS

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 AGENT 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 THAT 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 INTERESTS.

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, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.



1           5. NOTWITHSTANDING THIS DOCUMENT, YOU  
2 HAVE THE RIGHT TO MAKE MEDICAL AND OTHER  
3 HEALTH CARE DECISIONS FOR YOURSELF SO LONG  
4 AS YOU CAN GIVE INFORMED CONSENT WITH  
5 RESPECT TO THE PARTICULAR DECISION. IN  
6 ADDITION, NO TREATMENT MAY BE GIVEN TO YOU  
7 OVER YOUR OBJECTION, AND HEALTH CARE  
8 NECESSARY TO KEEP YOU ALIVE MAY NOT BE  
9 STOPPED IF YOU OBJECT.

10          6. YOU HAVE THE RIGHT TO REVOKE THE  
11 APPOINTMENT OF THE PERSON DESIGNATED IN  
12 THIS DOCUMENT TO MAKE HEALTH CARE  
13 DECISIONS FOR YOU BY NOTIFYING THAT PERSON  
14 OF THE REVOCATION ORALLY OR IN WRITING.

15          7. YOU HAVE THE RIGHT TO REVOKE THE  
16 AUTHORITY GRANTED TO THE PERSON  
17 DESIGNATED IN THIS DOCUMENT TO MAKE  
18 HEALTH CARE DECISIONS FOR YOU BY NOTIFYING  
19 THE TREATING PHYSICIAN, HOSPITAL OR OTHER  
20 PROVIDER OF HEALTH CARE ORALLY OR IN  
21 WRITING.

22          8. THE PERSON DESIGNATED IN THIS  
23 DOCUMENT TO MAKE HEALTH CARE DECISIONS  
24 FOR YOU HAS THE RIGHT TO EXAMINE YOUR  
25 MEDICAL RECORDS AND TO CONSENT TO THEIR  
26 DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN  
27 THIS DOCUMENT.

28          9. THIS DOCUMENT REVOKES ANY PRIOR  
29 DURABLE POWER OF ATTORNEY FOR HEALTH  
30 CARE.

31          10. IF THERE IS ANYTHING IN THIS DOCUMENT  
32 THAT YOU DO NOT UNDERSTAND, YOU SHOULD  
33 ASK A LAWYER TO EXPLAIN IT TO YOU.

34  
35           1. DESIGNATION OF HEALTH CARE AGENT.

36           I, .....  
37 (insert your name) do hereby designate and appoint:

38                           Name: .....

39                           Address: .....

40                           Telephone Number: .....

41



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1 as my agent to make health care decisions for me as  
2 authorized in this document.

3 (Insert the name and address of the person you wish to  
4 designate as your agent to make health care decisions for you.  
5 Unless the person is also your spouse, legal guardian or the  
6 person most closely related to you by blood, none of the  
7 following may be designated as your agent: (1) your treating  
8 provider of health care; (2) an employee of your treating  
9 provider of health care; (3) an operator of a health care  
10 facility; or (4) an employee of an operator of a health care  
11 facility.)

12 2. CREATION OF DURABLE POWER OF  
13 ATTORNEY FOR HEALTH CARE.

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

18 3. GENERAL STATEMENT OF AUTHORITY  
19 GRANTED.

20 In the event that I am incapable of giving informed  
21 consent with respect to health care decisions, I hereby grant  
22 to the agent named above full power and authority: to make  
23 health care decisions for me before or after my death,  
24 including consent, refusal of consent or withdrawal of  
25 consent to any care, treatment, service or procedure to  
26 maintain, diagnose or treat a physical or mental condition; to  
27 request, review and receive any information, verbal or  
28 written, regarding my physical or mental health, including,  
29 without limitation, medical and hospital records; to execute  
30 on my behalf any releases or other documents that may be  
31 required to obtain medical care and/or medical and  
32 hospital records, EXCEPT any power to enter into any  
33 arbitration agreements or execute any arbitration clauses in  
34 connection with admission to any health care facility  
35 including any skilled nursing facility; and subject only to the  
36 limitations and special provisions, if any, set forth in  
37 paragraph 4 or 6.

38 4. SPECIAL PROVISIONS AND LIMITATIONS.

39 (Your agent is not permitted to consent to any of the  
40 following: commitment to or placement in a mental health  
41 treatment facility, convulsive treatment, psychosurgery,  
42 sterilization or abortion. If there are any other types of  
43 treatment or placement that you do not want your agent's  
44 authority to give consent for or other restrictions you wish to  
45 place on his or her agent's authority, you should list them in





1 the space below. If you do not write any limitations, your  
2 agent will have the broad powers to make health  
3 care decisions on your behalf which are set forth in paragraph  
4 3, except to the extent that there are limits provided by  
5 law.)

6 In exercising the authority under this durable power of  
7 attorney for health care, the authority of my agent is subject  
8 to the following special provisions and limitations:

9 .....  
10 .....  
11 .....  
12 .....

13  
14 5. DURATION.

15 I understand that this power of attorney will exist  
16 indefinitely from the date I execute this document unless I  
17 establish a shorter time. If I am unable to make health care  
18 decisions for myself when this power of attorney expires, the  
19 authority I have granted my agent will continue to exist until  
20 the time when I become able to make health care decisions  
21 for myself.

22  
23 (IF APPLICABLE)

24 I wish to have this power of attorney end on the  
25 following date: .....

26  
27 6. STATEMENT OF DESIRES.

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



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

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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, if this subparagraph is initialed.)

[.....]

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, 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 agent 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: .....

.....  
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.....  
.....

7. DESIGNATION OF ALTERNATE AGENT.

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

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

A. First Alternative Agent

Name: .....

Address: .....

Telephone Number: .....

B. Second Alternative Agent

Name: .....

Address: .....

Telephone Number: .....

8. PRIOR DESIGNATIONS REVOKED.

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

9. WAIVER OF CONFLICT OF INTEREST.

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.



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10. CHALLENGES.

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

11. NOMINATION OF GUARDIAN.

If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

12. RELEASE OF INFORMATION.

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

(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.)



1 State of Nevada }  
 2 }  
 3 County of..... } ss.  
 4 }

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

15  
 16 NOTARY SEAL .....  
 17 (Signature of Notary Public)  
 18

19 STATEMENT OF WITNESSES

20  
 21 (You should carefully read and follow this witnessing  
 22 procedure. This document will not be valid unless you  
 23 comply with the witnessing procedure. If you elect to use  
 24 witnesses instead of having this document notarized, you  
 25 must use two qualified adult witnesses. None of the following  
 26 may be used as a witness: (1) a person you designate as the  
 27 agent; (2) a provider of health care; (3) an employee of a  
 28 provider of health care; (4) the operator of a health care  
 29 facility; or (5) an employee of an operator of a health care  
 30 facility. At least one of the witnesses must make the  
 31 additional declaration set out following the place where the  
 32 witnesses sign.)

33 I declare under penalty of perjury that the principal is  
 34 personally known to me, that the principal signed or  
 35 acknowledged this durable power of attorney in my presence,  
 36 that the principal appears to be of sound mind and under no  
 37 duress, fraud or undue influence, that I am not the person  
 38 appointed as agent by this document and that I am not a  
 39 provider of health care, an employee of a provider of health  
 40 care, the operator of a ~~community~~ health care facility or an  
 41 employee of an operator of a health care facility.

42  
 43 Signature: ..... Residence Address: .....  
 44 Print Name: .....  
 45 Date: .....



1           Signature: .....           Residence Address: .....  
 2           Print Name: .....           .....  
 3           Date: .....           .....  
 4

5                   (AT LEAST ONE OF THE ABOVE WITNESSES MUST  
 6                   ALSO SIGN THE FOLLOWING DECLARATION.)  
 7

8                   I declare under penalty of perjury that I am not related to  
 9                   the principal by blood, marriage or adoption and that to the  
 10                  best of my knowledge, I am not entitled to any part of the  
 11                  estate of the principal upon the death of the principal under a  
 12                  will now existing or by operation of law.  
 13

14                  Signature: .....

15                  Signature: .....

16                  Names: .....           Address: .....  
 17                  Print Name: .....           .....  
 18                  Date: .....           .....  
 19

20                  COPIES: You should retain an executed copy of this  
 21                  document and give one to your agent. The power of attorney  
 22                  should be available so a copy may be given to your providers  
 23                  of health care.  
 24

25                  **Sec. 7.** This act becomes effective upon passage and approval.  
 26  
 27

