Part I. Nevada 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.

STATUTORY WARNING

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.

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 OF THE REVOCATION 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.

STATUTORY WARNING (CONTINUED)

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.

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR AGENT

1. DESIGNATION OF HEALTH CARE AGENT.

I, Carl David Ericson, do hereby designate and appoint:
(name)

NAME: Jean E Ericson

ADDRESS: 1450 E Pebble Rd #3065, Las Vegas, NV 89123

TELEPHONE NUMBER: 702-538-3486

as my Agent 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 agent to make health care decisions for you. Unless the person you designate is your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your agent: (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 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 agent 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; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required to obtain medical care and/or medical and hospital records, EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility, and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISION AND LIMITATIONS.

(Your agent 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 agent's authority to give consent for or other restrictions you wish to place on his or her authority, you should list them in the space below. If you do not write any limitations, your agent 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 agent is subject to the following special provisions and limitations:

ADD ADDITIONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE SCOPE OF YOUR AGENT'S AUTHORITY

_____

_____

_____

_____

_____

_____

_____

_____

5. DURATION.

PRINT THE EXPIRATION DATE (OPTIONAL)

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.

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 agent 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 agent 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 line next to the statement.)

INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES (OPTIONAL)

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.

Initial _____

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.

Initial CDE

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.

Initial CDE

ANY INSTRUCTIONS ON THE USE OF LIFE-SUSTAINING OR PROLONGING TREATMENTS SHOULD BE CONSISTENT WITH INSTRUCTIONS PROVIDED IN YOUR NEVADA DECLARATION (PART II), IF ANY

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 gastro-intestinal tract after all other treatment is withheld.

Initial _____

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.

Initial CDE

(If you wish to change your answer, you may draw an "X" through the answer you do not want, circle the answer you prefer, and initial the changes)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

6. Other or Additional Statements of Desires:

(Attach additional pages if needed)

7. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternate agent but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 3 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:

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR FIRST ALTERNATE AGENT

A. First Alternate Agent

Name: Lynn Grubbs

Address: 1353 Avonwood Ct., Lutz, FL 33559

Telephone Number: 813-949-3799

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR SECOND ALTERNATE AGENT

B. Second Alternate 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.

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. The durable power of attorney for health care must be construed and interpreted in accordance with the laws of the State of Nevada.

This section is not required, and you may cross it out if you desire.

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.

PART II ONLY APPLIES TO WITHHOLDING OR WITHDRAWING OF LIFE-SUSTAINING TREATMENTS IF YOU ARE TERMINALLY ILL

BECAUSE PART II IS LIMITED IN THIS WAY, IF YOU PLAN TO COMPLETE PART I, YOU MAY WISH TO LEAVE PART II BLANK AND RECORD YOUR ADVANCE PLANNING WISHES IN PART I.

INITIAL ONLY ONE

ADD ADDITIONAL INSTRUCTIONS, IF ANY, IN THE EVENT YOU HAVE A TERMINAL CONDITION

ATTACH ADDITIONAL PAGES IF NEEDED

Part II: Declaration Relating to the Use of Life-Sustaining Treatment

If I should lapse into 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 (a terminal condition) and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Nevada Uniform Act on the Rights of the Terminally Ill, to:

CDE 1. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 2. Keep me comfortable and allow natural death to occur. I do not want any life-sustaining treatment or other medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

((or))

_____ 3. Try to extend my life for as long as possible, using all available life-sustaining treatment or other medical interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

Any questions regarding how to interpret or apply my declaration shall be resolved by my agent appointed under a durable power of attorney for health care (Part I), if I have appointed one.

I further direct that:

_____

_____

_____

_____

(Attach additional pages if needed)

PART III: EXECUTION

Nevada requires that you execute your form using the Nevada statutory language, which is reflected in the forms below.

If you fill out Part II, you must sign your form in front of two witnesses and use the Nevada statutory language.

If you fill out Part I, you can make your advance directive legal in one of two ways.

1. Sign your document in the presence of two witnesses and use the Nevada statutory language. These witnesses cannot be:

- the person you name as your agent,
- a health care provider,
- an employee of a health care provider,
- an operator of a health care facility, or
- an employee or an operator of a health care facility.

At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or by operation of law.

Signing your document in this way will also make Part II legal.

OR

2. Have your signature witnessed by a notary public and use the Nevada statutory language. Having your signature notarized will only make Part I legal (i.e., Part II needs an additional witness besides the notary).

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

IF YOU FILLED OUT PART II, YOU MUST HAVE YOUR DOCUMENT WITNESSED

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

REQUIRED STATEMENT BY ONE OF THE ABOVE WITNESSES IF YOU FILLED OUT PART I

Alternative No. 1: Sign before witnesses.

I sign my name to this Durable Power of Attorney for Health Care on

27 March 2016 (date) at Las Vegas (city), NV (state).

(signature)

Carl David Ericson

(print name)

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, and 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 community care facility or an employee of an operator of a health care facility.

Witness 1:

Signature: _____ Residence Address: _____

Print Name: James R De Bolt 1450 E Pebble

Date: 3-27-16 LV NV 89123 3071

Witness 2:

Signature: _____ Residence Address: _____

Print Name: Steve Kellogg 1450 E Pebble Rd 304

Date: 3-27-16 LV NV 89123

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that 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: _____ Residence Address: _____

Print Name: Steve Kellogg 1450 E Pebble Rd 304

Date: 3-27-16 LV NV 89123

SIGNING BEFORE A NOTARY PUBLIC IS ONLY AN OPTION IF YOU DID NOT FILL OUT PART II

Alternative No. 2: Sign before a notary public.

I sign my name to this Durable Power of Attorney for Health Care on

_____ at _____, _____.
(date) (city) (state)

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____
(signature)

_____
(print name)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)
) ss.
County of _____)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

On this _____ day of _____, in the year _____,
before me, _____, personally appeared
(name of notary public)

_____
(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)

ASK YOUR TREATING PHYSICIAN, PSYCHOLOGIST, OR PSYCHIATRIST TO FILL THIS OUT

PART IV: CERTIFICATION OF COMPETANCY

If you reside in a hospital, residential facility for groups, facility for skilled nursing, or home for individual residential care, Nevada requires that you include a certification of competency from a physician, psychologist, or psychiatrist along with your power of attorney:

PRINT YOUR NAME HERE

The undersigned treating (physician/psychologist/psychiatrist) of _____ states as follows:

1. That I am a licensed (physician/psychologist/psychiatrist) practicing in the State of _____, and I have been a licensed (physician/psychologist/psychiatrist) for ____ years. My present address is _____.

PRINT YOUR NAME HERE

2. That I have examined _____ and have concluded as a result of that examination that the he/she is mentally competent to understand the nature of the Durable Power of Attorney for Health Care proceedings and the delegation of authority to an agent.

_____

(Signature of certifying physician/psychologist/psychiatrist) (Date)

_____

(Name of certifying physician/psychologist/psychiatrist)

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898