13 -

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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 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.

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.

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 ATTORNEY-IN-FACT. I, Cecila A. Hardwicke, do hereby designate and appoint:

Attorney-in-Fact:	Donna Ann Chizek	
Address:	PO Box 2263 Minden, Nevada 89423	
Phone:	Home: (702) 267-2631	Work: (702) 782-9218
Relation, if any:	Daughter	

as my Attorney-in-Fact ("Agent") to make health care decisions for me as authorized in this document.

NOTE: Unless the person is also your spouse, legal guardian or 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: If I require hospitalization I do not want to be sent to Carson Tahoe Hospital. I wish to go to Washoe Medical Center instead.

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.

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 compose your own statements.)

(If the statement reflects your desires, initial the line below the statement.)

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 449.540 to 449.690, inclusive, (Uniform Act on Rights of the Terminally Ill) if this subparagraph is initialed.)

Ch
(Initials)

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 449.540 to 449.690, inclusive, (Uniform Act on Rights of the Terminally Ill) if this subparagraph is initialed.)

Ch
(Initials)

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.

(Initials)

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT. (You are not required to designate any Alternate Attorney-in-Fact but you may do so. Any Alternate 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 3, 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 persons 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:

FIRST ALTERNATE ATTORNEY-IN-FACT

Attorney-in-Fact:	Madeline Mary Romero
Address:	1052 14th Street Wasco, California 93280
Phone:	Home: (805) 758-8145

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior Durable Power of Attorney for Health Care.

9. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.

10. SEVERABILITY. If any provision of this document is held to be invalid, such invalidity

shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

11. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period in which I am unable to make such decisions.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on this 3 day of April, 1997, at Carson City, Nevada.

Cecilia A Hardwicke
Signature

Principal Name: ~~Cecila~~ CECILIA A. Hardwicke
Principal Address: PO. BOX 3099 Carson City
Carson City County
Nevada

(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.)

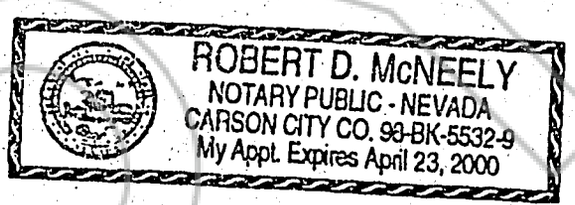
CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(You may use acknowledgement before a Notary Public instead of the statement of witnesses.)

STATE OF NEVADA)
) ss:
COUNTY OF Carson City)

On this 3rd day of April, 1997, before me, ROBERT D. McNEELY personally appeared, Cecila A. Hardwicke, 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



Robert D. McNeely
Signature of Notary Public

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.

REQUESTED BY
Cecilia A Hardwicke
IN OFFICIAL RECORDS OF
DOUGLAS CO., NEVADA

'97 APR -4 A10:22

LINDA SLATER
RECORDER
$13.00 PAID K2 DEPUTY

✓ CECILIA A. HARDWICKE
PO Box 3099
CARSON CITY, NV 89702-3099

0409951

BK0497PG0649