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 ATTORNEY-IN-FACT (HEALTH CARE 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 OR DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN, OR TO ACT IN YOUR BEST INTERESTS, IF YOUR DESIRES ARE UNKNOWN.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY HAVE THE POWER TO GIVE CONSENT TO YOUR DOCTOR TO NOT GIVE TREATMENT OR TO STOP 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

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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 AGENT. I, DONALD WAYNE STUKEY, do hereby designate and appoint:

(On the next page insert the name and address of the person you wish to designate as your attorney-in-fact [health care agent] to make health care decisions for you. The following may not be designated as your health care agent: (1) your treating health care provider, (2) an employee of your treating health care provider, (3) an operator of a health care facility, or (4) an employee of an operator of a health care facility.)

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Name: BRENDA MEREDITH STUKEY

Address: 1523 Mill Creek Way, Gardnerville, Nevada 89410

Telephone Number: (775) 782-3142

as my attorney-in-fact (health care agent) to make health care decisions for me as authorized in this document.

2. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT.

(You are not required to designate an alternate attorney-in-fact [health care agent], but you may wish to do so. Any alternate attorney-in-fact will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1 in the event that your first choice is unable or unwilling to act as your health care agent. 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 alternate co-attorneys-in-fact to make health care decisions for me as authorized in this document:

Alternate Co-Attorneys-in-fact:

Name: THOMAS WAYNE STUKEY

Address: 2829 Camino Calandria, Thousand Oaks, California 91360

Telephone Number: (805) 492-3201

and

Name: CARYN ANNE HARPER

Address: 2950 Sarah Court, Newbery Park, California 91320

Telephone Number: (805) 499-2761

In the event either THOMAS WAYNE STUKEY or CARYN ANNE HARPER should predecease me or any reason be unable or unwilling to serve, I nominate and designate the remaining

alternate co-attorney-in-fact to act as my successor attorney-in-fact to make health care decisions for me as authorized in this document.

3. 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.

4. 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 above named full power and authority to make health care decisions for me 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 paragraphs 5 or 6.

5. 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 interest. Under some circumstances a court may determine the health care decision that is in your best interest. If you wish to indicate your desires, you may initial the statement or statements that reflect your desires and/or write your own statement in the space provided below.)

________ (Initial here if this reflects your desires.)	1. I desire that my life be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, my long term survival or the cost of the procedures.
________ (Initial here if this reflects your desires.)	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.

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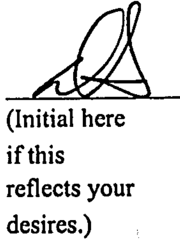
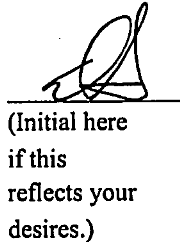
(You should also utilize provisions of NRS 449.610 et seq. - Directive to Physicians - if this subparagraph is initialed.)

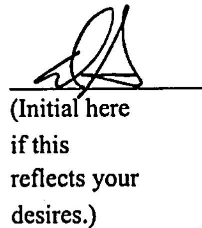

(Initial here if this reflects your desires.)

3. If I have an incurable or terminal condition or illness and there is no reasonable hope of long term recovery or survival, I desire that life sustaining or prolonging treatments not be used.

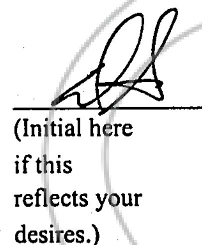
(You should also utilize provisions of NRS 449.610 et seq. - Directive to Physicians - if this subparagraph is initialed.)


(Initial here if this reflects your desires.)

4. 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 of my life if it is prolonged.


(Initial here if this reflects your desires.)

5. If at such a time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or "heroic measures". I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.


(Initial here if this reflects your desires.)

6. I direct my attorney-in-fact to ensure that I receive adequate medication to relieve pain. If, in the opinion of my attorney-in-fact, I am not receiving an adequate level of pain medication to manage and relieve my pain, I authorize and direct my attorney-in-fact to contact both the Mayday Fund at (212) 649-5800 and the Memorial Sloan-Kettering Pain Management Hotline at (212) 639-7918 in Washington,

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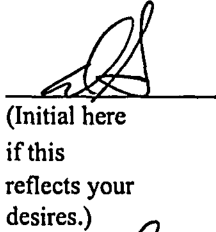
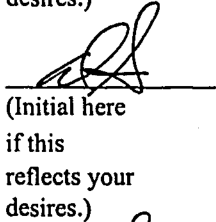
D.C.

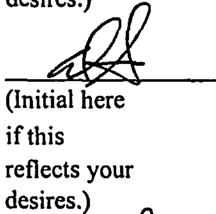
7. Means of artificial life support in the face of impending death that I specifically refuse are:


(Initial here if this reflects your desires.)

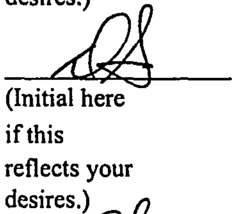
(a) electrical or mechanical resuscitation of my heart when it has stopped beating.


(Initial here if this reflects your desires.)

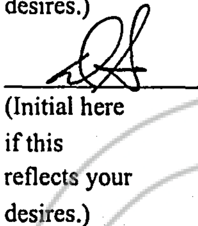
(b) nasogastric tube feeding when I am paralyzed or unable to take nourishment by mouth.


(Initial here if this reflects your desires.)

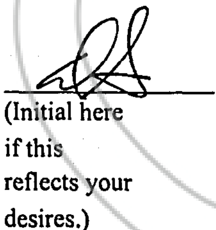
(c) gastro-intestinal tube feeding when I am paralyzed or unable to take nourishment by mouth.


(Initial here if this reflects your desires.)

(d) mechanical respiration when I am no longer able to sustain my own breathing.


(Initial here if this reflects your desires.)

8. I would like to live out my last days at home rather than in a hospital if it does not jeopardize the chance of my recovery to a meaningful and sentient life or does not impose an undue burden on my family.


(Initial here if this reflects your desires.)

9. If any of my tissues are sound and would be of value as transplant to other people, I freely give my permission for such donation pursuant to the Uniform Anatomical Gift Act.

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

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Other or Additional Statement of Desires: ______________________________

____

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____

____

6. SPECIAL PROVISIONS AND LIMITATIONS.

(Your attorney-in-fact [health care 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 restrictions on treatments or placements, or any other limitations on the authority you give to your attorney-in-fact, 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 4, except to the extent that there are limits provided by law.)

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

____

7. 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, fill in the following blank.)

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

____

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney

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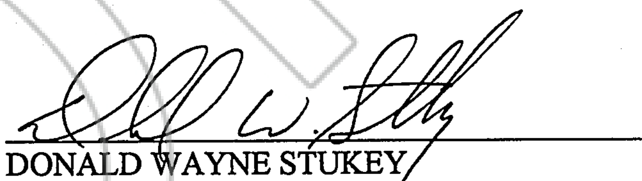
for health care.

9. WAIVER OF CONFLICT OF INTEREST. As my designated agents are my spouse and children, I waive any conflict of interest that my spouse or children may have in carrying out the provisions of this Durable Power of Attorney for Health Care Decisions, by reason of the fact that my spouse or children may be a recipient of my estate whether by Will, the laws of intestate succession or pursuant to a Trust or any other arrangement.

10. DECLARATORY JUDGMENT. If the legality of any provision of this durable power of attorney is questioned by my attorney-in-fact, or my doctor then my attorney-in-fact is authorized, in his or her sole discretion, to commence an action for a declaratory judgment as to the legality of carrying out any provision of this Durable Power of Attorney for Health Care Decisions. The cost of any such action is to be paid for from my estate.

I sign my name to this Durable Power of Attorney for Health Care Decisions on this 23RD day of JUNE, 1999, at Gardnerville, Nevada.



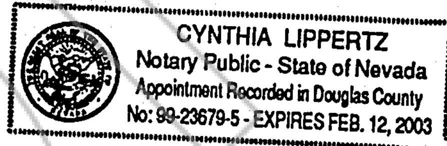
DONALD WAYNE STUKEY

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF NEVADA)
: ss
COUNTY OF DOUGLAS)

On this 23rd day of June, in the year 1999, before me, Cynthia Lippertz personally appeared DONALD WAYNE STUKEY, 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 to me that he executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and does not appear to be under duress, fraud or undue influence.

Cynthia Lippertz
Notary Public



COPIES

You should keep an executed copy of this document and give one to your attorney-in-fact. Do not place this power of attorney in your safe deposit box. It should be kept readily available so a copy may be given to your health care providers.

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REQUESTED BY
Brenda Stakey
IN OFFICIAL RECORDS OF
DOUGLAS CO., NEVADA

'99 JUN 23 P2:38

LINDA SLATER
RECORDER
$16.00 PAID KO DEPUTY

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