

OFFICIAL RECORD

Requested By:
PATRICK JAMES MARTIN

**DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS
GIVEN BY**

ROY T. COLLIER, SR.

AS PRINCIPAL

Douglas County - NV
Werner Christen - Recorder

Page: 1 Of 11 Fee: 24.00
BK-1106 PG- 9783 RPTT: 0.00



**THIS POWER OF ATTORNEY IS NOT AFFECTED
BY DISABILITY OF THE PRINCIPAL**

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.

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY
ROY T. COLLIER, SR.**

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.

ARTICLE 1

DESIGNATION OF HEALTH CARE AGENT AND ALTERNATE AGENT

1.1 DESIGNATION OF HEALTH CARE AGENT

I, Roy T. Collier, Sr., do hereby designate and appoint:

Name: Mary Ann Collier
Address: 2315 Kincaid Avenue,
PO Box 38
Minden, Nevada 89423
Telephone number: (775) 267-2445

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

1.2 INFORMATIONAL NOTE

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 unless that person is also your spouse, legal guardian or the most person most closely related to you by blood.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY ROY T. COLLIER, SR.

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-2-

1.3 DESIGNATION OF ALTERNATE AGENTS

If the person designated in paragraph 1.1 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 person to serve in the order listed below:

1.3.1 First Alternative Attorney-in-fact:

First: Nancy J. (Collier) Benton
Address: 970 Woodvale Avenue
Dixon, CA 95620
Telephone number: (707) 678-3453

Second: Terri L. (Collier) Stumbaugh
Address: 9022 E. Avenue T-8
Little Rock, CA 93543
Telephone number: (661) 944-2976

1.4 INFORMATIONAL NOTE

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 1.1, in the event that he or she is unable or unwilling to act as your attorney-in-fact.

ARTICLE 2

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

2.1 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.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY
ROY T. COLLIER, SR.

A\Collier 6/10/2005 disk\HC\Power Roy.wpd\1315.0001

-3-

ARTICLE 3

GENERAL STATEMENT OF AUTHORITY GRANTED

3.1 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 Article 4 or 6.

ARTICLE 4

SPECIAL PROVISIONS AND LIMITATIONS

4.1 INFORMATIONAL NOTE

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 your 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 3.1, except to the extent that there are limits provided by law.

4.2 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:

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY
ROY T. COLLIER, SR.**

AVCollier 6/10/2005 disk\HCPower Roy.wpd\1315.0001

-4-



ARTICLE 5

DURATION

5.1 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:

ARTICLE 6

STATEMENT OF DESIRES

6.1 INFORMATIONAL NOTE

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. 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.

6.1.1 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.

INITIALS

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY
ROY T. COLLIER, SR.**

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-5-

6.1.2 If I am in a coma and the coma lasts over a period of three (3) months and the doctors conclude there's no chance of recovery, and Mary Ann Collier, Nancy J. (Collier) Benton and Terri L. (Collier) Stumbaugh believes that there is no chance, then pull the plug.

R.T.C.
(INITIALS)

6.1.3 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. Please note that I have executed a Declaration Directing Withholding or Withdrawal of Life-Sustaining Treatment pursuant to NRS 449.535 to NRS 449.690, inclusive.

(INITIALS)

6.1.4 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.

(INITIALS)

6.1.5 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.

(INITIALS)

6.1.6 Other or Additional Statement of Desires:

If I have an incurable or terminal disease, I want nourishment, water, and pain killers as long as God sees fit. This may be in the home or Hospice.

R.T.C.
(INITIALS)

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY
ROY T. COLLIER, SR.

A\Collier 6/10/2005 disk\HC Power Roy.wpd\1315.0001

-6-

ARTICLE 7

PRIOR DESIGNATIONS REVOKED

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

ARTICLE 8

YOU MUST SIGN AND DATE THIS POWER OF ATTORNEY

8.1 I sign my name to this General Durable Power of Attorney for Health Care on 11-15-06, _____, at Reno, Nevada.



Roy T. Collier, Sr., Principal

8.2 INFORMATIONAL NOTE

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.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY
ROY T. COLLIER, SR.

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-7-

8.3 CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF NEVADA)
) ss.
COUNTY OF WASHOE)

On November 15, 2006, before me, a Notary Public, personally appeared **Roy T. Collier, Sr.**, 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 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.

Breanne Deater
NOTARY PUBLIC



8.4 STATEMENT OF WITNESSES

8.4.1 INFORMATIONAL NOTE

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 the witnesses must make the additional declaration set out following the place where the witnesses sign.

8.4.2 ATTESTATION AFFIDAVIT

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 Roy T. Collier, Sr. 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.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY ROY T. COLLIER, SR.

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Signature: [Signature]

Print Name: Amy Scalia

Date: November 15, 2006

Residence Address: 1029 Sticklebract Drive
Sparks, NV 89441

Signature: [Signature]

Print Name: Priscilla Joanne Martin

Date: November 15, 2006

Residence Address: 115 Ripon Street
Reno, Nevada 89501-1937

8.5 ATTESTATION AFFIDAVIT - ADDITIONAL DECLARATION

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 Roy T. Collier, Sr. by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of Roy T. Collier, Sr. upon the death of Roy T. Collier, Sr. under a will now existing or by operation of law.

Signature: [Signature]

Print Name: Amy Scalia

Date: November 15, 2006

Residence Address: 1029 Sticklebract Drive
Sparks, NV 89441

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY ROY T. COLLIER, SR.

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Signature: Mark

Print Name: Poracua Jami Miron

Date: November 15, 2006

Residence Address: 115 Linden Street
Riv, Minn 5501-1957

8.6 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.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GIVEN BY
ROY T. COLLIER, SR.

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-10-



<p>ADDRESS OF PRINCIPAL: Roy T. Collier, Sr. 2315 Kincaid Avenue P.O. Box 38 Minden, Nevada 89423</p>	<p>RECORDING REQUESTED BY: Law Office Patrick James Martin Chartered 115 Ridge Street Reno, NV 89501-1937</p>
<p>ADDRESS OF AGENT: Mary Ann Collier 2315 Kincaid Avenue P.O. Box 38 Minden, Nevada 89423</p>	<p>UPON RECORDING RETURN TO: Law Office Patrick James Martin Chartered 115 Ridge Street Reno, NV 89501-1937</p>
<p>ADDRESS OF ALTERNATE AGENTS: Nancy J. (Collier) Benton 970 Woodvale Avenue Dixon, CA 95620 Terri L. (Collier) Stumbaugh 9022 E. Avenue T-8 Little Rock, CA 93543</p>	<p>RECORDER'S STAMP:</p>
<p>CERTIFICATION: <input checked="" type="checkbox"/> I hereby affirm that this document submitted for recording purposes <u>does not</u> contain a social security number. or <input type="checkbox"/> I hereby affirm that this document submitted for recording purposes contains a social security number of a person as required by law: _____</p> <p><i>Patrick James Martin</i> _____ Signature Title</p> <p><i>Patrick James Martin</i> _____ Print name</p>	