JA-

Assessor's Parcel Number: _____

Recording Requested By:

Name: Charles Roach

Address: PO Box 2951

City/State/Zip Minden, NV 89423

Real Property Transfer Tax: _____

DOC # 0710128
09/28/2007 09:50 AM Deputy: GB
OFFICIAL RECORD
Requested By:
CHARLES ROACH

Douglas County - NV
Werner Christen - Recorder
Page: 1 Of 11 Fee: 24.00
BK-0907 PG-7020 RPTT: 0.00

Power of Attorney
(Title of Document)

This page added to provide additional information required by NRS 111.312 Sections 1-2. (Additional recording fee applies)

This cover page must be typed or legibly hand printed.

C\bc docs\Cover page for recording

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DURABLE POWER OF ATTORNEY
(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 KNOWN 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 DECISION 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.

DURABLE POWER OF ATTORNEY (CONTINUED)

1. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE:

By this document I, EVA J. ROACH, intend to create a durable power of attorney by appointing the person(s) designated below to make health care decisions for me. This power of Attorney shall not be affected by my subsequent incapacity.

2. DESIGNATION OF HEALTH CARE AGENT:

I, EVA J. ROACH, do hereby designate and appoint the following to serve as my attorney-in-fact, who is not any of the following, (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, to make health care decisions for me as authorized in this document:

NAME: **CHARLES E. ROACH**
ADDRESS: **1739 Westwood Drive**
Minden, NV 89423
(702)782-2808

3. GENERAL STATEMENT OF AUTHORITY GRANTED:

In the event that I become incapable of giving an informed consent with respect health care decision, 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 5 or 7.

4. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT:

(You are not required to designated any alternative 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 2, in the event that he is unable or unwilling to act as your attorney-in-fact . Also, if the attorney-in-fact designated in paragraph 2 is your spouse, his designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

3rd set

If the person designated in paragraph 2 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorneys-in-fact, who are not any of the following, (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, to make health care decisions for me as authorized in this document:

A. First Alternative Attorney-in-fact

NAME: **SANDRA STONE**
ADDRESS: _____
_____
(____)_____

B. Second Alternate Attorney-in-fact

NAME: **JULIE SARGENT**
ADDRESS: _____
_____
(____)_____

5. 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/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.

_____
_____
_____
_____
_____
_____
_____
_____

6. 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)
I wish to have this power of attorney end on the following date: _____.

7. STATEMENT OF DESIRES:

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must have health care decisions that are consistent with your own 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 line at the bottom of the statement)

(a) I desire that may 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. _____

(b) 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.) _____

(c) 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.)
_____

(d) I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastro-intestinal tract if such a withholding or withdrawal would result in my death by starvation or dehydration.

_____

(e) 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. _____

(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:

_____
_____
_____
_____
_____
_____

8. PRIOR DESIGNATIONS REVOKED:

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

9. DATE AND SIGNATURE OF PRINCIPAL:

I sign my name to this Durable Power of Attorney for Health Care on 25 August 1993, in the County of Washoe, State of Nevada.

Eva J. Roach
EVA J. ROACH

(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)
County of Washoe)

On 25 August, 1993, before me, the undersigned, a Notary Public in and for said County and State, personally appeared EVA J. ROACH, known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged he executed the same.

WITNESS my hand and Official Seal.

BONNIE BEMIS
Notary Public - State of Nevada
Appointment Recorded in Washoe County
MY APPOINTMENT EXPIRES APR. 9, 1994

Bonnie Bemis
Notary Public in and for said County

STATEMENT OF WITNESSES

(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 of the witnesses must make the additional declaration set our 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 attorney-in-fact by this document, and that I am not a provided of health care, an employee of a provider of health care, the operator of a community care facility, nor any employee of an operator of a health care facility.

Signature: Karen L. Ewart Address: 955 S. Virginia

Print Name: KAREN L. EWART Reno, NV 89502

Date: 8-25-93

Signature: Carla J. King Address: 955 So. Virginia

Print Name: Carla J. King Reno, NV 89502

Date: 8/25/93

(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 principal by blood, marriage, or adoption, and 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 not existing or by operation of law.

Signature: Karen L. Ewart Address: 955 S. Virginia

Print Name: KAREN L. EWART Reno, NV 89502

Date: 8-25-93

Signature: Carla J. King Address: 955 So. Virginia

Print Name: Carla J. King Reno, NV 89502

Date: 8/25/93

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.

15. CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC:

STATE OF Nevada)
COUNTY OF Washoe)

On this 25 day of August in the year of 1993, before me, the undersigned, a Notary Public in and for said County and State , personally appeared CHARLES E. ROACH, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name subscribed to this instrument and acknowledged that he executed it.

WITNESS my hand and official seal.

Bonnie Bemis
Notary Public in and for said County

BONNIE BEMIS
Notary Public - State of Nevada
Appointment Recorded in Washoe County
MY APPOINTMENT EXPIRES APR. 9, 1994

DURABLE POWER OF ATTORNEY
(FINANCIAL DECISIONS)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. This document provides the person you designate as your Attorney-in-Fact with broad powers to dispose, sell, convey and encumber your real and personal property.

2. These powers will exist for an indefinite period of time unless you limit their duration in this document. These powers will continue to exist notwithstanding your subsequent disability or incapacity .

3. You have the right to revoke or terminate this Durable Power of Attorney at any time.

BK- 0907
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