DOUGLAS COUNTY, NV
Rec:$40.00
Total:$40.00
HELEN DAKIN

2021-960875
01/28/2021 03:47 PM
Pgs=15

0012750120210960875015O157

KAREN ELLISON, RECORDER

APN# _____

Recording Requested by/Mail to:

Name: Helen M. Dakin

Address: 1452 Sally Ln

City/State/Zip: Gardnerville, NV 89460

Mail Tax Statements to:

Name: Helen. M. Dakin

Address: P.O. Box 1194

City/State/Zip: Gardnerville, NV 89410

Durable Power of Attorney for Health

Title of Document (required)

----------(Only use if applicable)----------

The undersigned hereby affirms that the document submitted for recording DOES contain personal information as required by law: (check applicable)

___Affidavit of Death – NRS 440.380(1)(A) & NRS 40.525(5)

___Judgment – NRS 17.150(4)

___Military Discharge – NRS 419.020(2)

_____
Signature

_____
Printed Name

This document is being (re-)recorded to correct document #_____, and is correcting _____ _____ _____.

Advance Directive for Health Care

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING (SIGNING) THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING (SIGNING) 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.
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.

DESIGNATION OF HEALTH CARE AGENT

I, Helen Margaret Dakin, of 1452 Sally Ln, Gardnerville, Nevada, do hereby designate and appoint Donna Renea Cupp, of Dayton, Nevada as my agent to make health care decisions for me as authorized in this document. Donna Renea Cupp's contact information is as follows:

Donna Renea Cupp
115 Southend Dr
Dayton, Nevada
89403
Telephone: (775) 720-7286

DESIGNATION OF ALTERNATE AGENT

If Donna Renea Cupp is unavailable or unable to make health care decisions for me, then I designate James W Cupp Jr, of Dayton, Nevada to serve as my agent to make health care decisions for me as authorized in this document. James W Cupp Jr's contact information is as follows:

James W Cupp Jr
115 Southend Dr
Dayton, Nevada

89403
Telephone: (775) 636-2996

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By executing this document, in which I appoint the persons designated above to make health care decisions for me, I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity.

GENERAL STATEMENT OF AUTHORITY GRANTED

My agent and my alternate agent are hereinafter referred to as "my Agent".

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to my Agent 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; and
- 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;

subject only to the limitations and special provisions, if any, set forth in this document.

SPECIAL PROVISIONS AND LIMITATIONS

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

- My Agent shall have access to any and all information regarding my physical or mental health, including medical and hospital records, in accordance with the *Health Insurance Portability and Accountability Act of 1996*, 42 USC 1320d ("HIPAA"); and

- My 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.

My Agent will not be subject to any limitations other than those specified in this document.

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 Agent will continue to exist until the time when I become able to make health care decisions for myself.

STATEMENT OF DESIRES

I grant my health care Agent the power to make any health care decision, including whether to withhold or withdraw life-sustaining treatment, as set out by me in the attached Declaration. Decisions required to be made by my Agent on matters not covered in the Declaration should be consistent with my known desires. My Agent is not authorized to make decisions other than on health care related matters.

PRIOR DESIGNATIONS REVOKED

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

WAIVER OF CONFLICT OF INTEREST

If my 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.

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. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

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.

EFFECT OF COPY

A copy of this Durable Power of Attorney for Health Care has the same effect as the original.

SEVERABILITY

If any part or parts of this Durable Power of Attorney for Health Care is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or parts shall not in any way affect the remaining parts, and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Durable Power of Attorney for Health Care would be substantially changed by such construction, then it shall not be so construed.

SIGNATURE

I sign my name to this Durable Power of Attorney for Health care on the 28th day of January, 2021, at Gardnerville, in the State of Nevada.

Helen Margaret Dakin

Helen Margaret Dakin

THIS POWER OF ATTORNEY IS NOT VALID **UNLESS**

IT IS SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO ME AND WHO WERE WITH ME WHEN I SIGNED, OR ACKNOWLEDGED MY SIGNATURE ON IT;

OR

I HAVE ACKNOWLEDGED MY SIGNATURE ON IT BEFORE A NOTARY PUBLIC.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

STATE OF NEVADA

COUNTY OF Douglas

On this 28th day of January, 2021, Helen Margaret Dakin personally appeared before me, 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 they executed it. I declare under penalty of perjury that Helen Margaret Dakin appears to be of sound mind and under no duress, fraud, or undue influence.

Patti Perry

Notary Public

PATTI PERRY
NOTARY PUBLIC
STATE OF NEVADA
No. 19-1988-5 My Appt. Exp. March 8, 2022

My commission expires: 03/08/2022

STATEMENT OF WITNESSES

(Use if not notarized.)

I declare under penalty of perjury that Helen Margaret Dakin is personally known to me, that Helen Margaret Dakin signed or acknowledged this durable power of attorney in my presence, that Helen Margaret Dakin 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, nor an employee of an operator of a health care facility.

Signature: _____

Print Name: _____

Address: _____

City, State: _____

Date: _____

Signature: _____

Print Name: _____

Address: _____

City, State: _____

Date: _____

(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 Helen Margaret Dakin by blood, marriage, or

adoption, and to the best of my knowledge I am not entitled to any part of the Helen Margaret Dakin's estate upon her death under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Address: _____

City, State: _____

Date: _____

RECORD OF COPIES

Record of people and institutions to whom I have given a signed copy of this document:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

DECLARATION

If I, Helen Margaret Dakin, become incapacitated and am unable to direct my health care providers as to my own health care, I direct that this statement be read as a true reflection of my health care wishes.

DEFINITIONS

For the purposes of this document, the following definitions apply:

1. **"Artificially administered food and water"** (or artificial nutrition and hydration) means the provision of nutrients or fluids by a tube inserted in vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).
2. **"Attending physician"** means the physician who has primary responsible for my treatment and care.
3. **"Comfort care"** means treatment, including prescription medication, provided to the patient for the sole purpose of alleviating pain. Artificially administered food and water is not included.
4. **"Health care provider"** or **"provider of health care"** means any person licensed, certified, or otherwise authorized by the law of the State of Nevada to administer health care in the ordinary course of business or practice of a profession.
5. **"Irreversible (Permanent) Coma"** means a profound state of unconsciousness caused by disease, injury, poison, or other means and for which it has been determined that there exists no reasonable expectation of regaining consciousness.
6. **"Life-prolonging procedure"** (or **"life-sustaining treatment"**) means a medical procedure or intervention that, when administered to a patient, serves only to prolong the dying process.
7. **"Persistent vegetative state"** means a permanent and irreversible condition in which there is:
    a. The absence of voluntary action or cognitive behavior of any kind.
    b. An inability to communicate or interact purposefully with the environment.
8. **"Terminal condition"** means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time.

MEDICAL DIRECTIONS AND END-OF-LIFE DECISIONS

I direct that my health care providers and others involved in my care, provide, withhold, or withdraw treatment in accordance with my directions below: (Review and initial where indicated)

1. If I have an incurable and irreversible (terminal) condition that will result in my death within a

relatively short time, I direct that:

- I be removed from any artificial life support or any additional life-prolonging treatment. _____ (my initials)
- I be artificially administered food and water, even if that has the effect of prolonging my life.
- I be provided comfort care, and relief from pain, including any pain reduction medication, even if doing so would prolong my life.

2. If I am diagnosed as being in an irreversible coma and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that

- I be removed from any artificial life support or any additional life-prolonging treatment. _____ (my initials)
- I be artificially administered food and water, even if that has the effect of prolonging my life.
- I be provided comfort care, and relief from pain, including any pain reduction medication, even if doing so would prolong my life.

3. If I am diagnosed as being in a persistent vegetative state and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that:

- I be removed from any artificial life support or any additional life-prolonging treatment. _____ (my initials)
- I be artificially administered food and water, even if that has the effect of prolonging my life.
- I be provided comfort care, and relief from pain, including any pain reduction medication, even if doing so would prolong my life.

PREGNANCY

If I am pregnant, I direct that my health care wishes be carried out as described in this document.

ADDITIONAL INSTRUCTIONS

I have no additional instructions.I understand that I may change the above-listed directives at any time by revoking this declaration and writing a new one.

EFFECT OF COPY

A copy of this Declaration has the same effect as the original.

SEVERABILITY

If any part or parts of this Declaration is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or parts shall not in any way affect the remaining parts, and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Declaration would be defeated by such construction, then it shall not be so construed.

SIGNATURE

This document is made upon careful reflection. Options that I have considered and rejected are not printed above. I confirm that the health care directions contained herein were made after careful consideration and in full awareness of other options that may have been available to me. I declare that I am an adult in the State of Nevada, that I understand the full import of this declaration, and that I am emotionally and mentally competent to give these directions.

Signed at Gardnerville, in the State of Nevada, this 28th day of January, 2021.

Signature: Helen Margaret Dakin
Name: Helen Margaret Dakin
Address: 1452 Sally Ln
Gardnerville, Nevada

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of the State of Nevada that:

1. The individual who signed or acknowledged this Declaration, Helen Margaret Dakin, is personally known to me, or her identity was proven to me by convincing evidence;
2. Helen Margaret Dakin appeared to be eighteen (18) years of age or older, or of the legal age in this state to create this type of document;
3. I am of at least eighteen (18) years of age and Helen Margaret Dakin signed or acknowledged this Declaration in my presence;
4. Helen Margaret Dakin appears to be of sound mind and under no duress, fraud, or undue influence;
5. I am not a person appointed as Helen Margaret Dakin's health care agent;
6. I am not Helen Margaret Dakin's health care provider, an employee of Helen Margaret Dakin's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly; and
7. I am not related to Helen Margaret Dakin by blood or marriage and I would not be entitled to any portion of Helen Margaret Dakin's estate on her death.

First witness	Second witness
_____	_____
(signature of witness)	(signature of witness)
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city) (state)	(city) (state)
_____	_____
(date)	(date)

RECORD OF COPIES

Record of people and institutions to whom I have given a signed copy of this document:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____