DOUGLAS COUNTY, NV
Rec:$40.00
Total:$40.00
ANTHONY FIELD

2021-976035
10/26/2021 01:53 PM
Pgs=14

00144472202109760350140144

KAREN ELLISON, RECORDER

APN# _____

Recording Requested by/Mail to:

Name: ANTHONY FIELD

Address: 1292 N SANTA BARBARA DR

City/State/Zip: MINDEN, NV 89423

Mail Tax Statements to:

Name: _____

Address: _____

City/State/Zip: _____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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

ANTHONY FIELD
Printed Name

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

_____

_____

_____.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(Including Advanced Directive to Physicians and Designation of Personal Representative under HIPAA)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE (HEREINAFTER REFERRED TO AS "Power of Attorney"). 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 OR ADVANCED PRACTICE REGISTERED NURSE 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 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 DECIDE WHERE YOU LIVE, EVEN AS YOU AGE. DECISIONS ABOUT WHERE YOU LIVE ARE PERSONAL. SOME PEOPLE LIVE AT HOME WITH SUPPORT, WHILE OTHERS MOVE TO ASSISTED LIVING FACILITIES OR FACILITIES FOR SKILLED NURSING. IN SOME CASES, PEOPLE ARE MOVED TO FACILITIES WITH LOCKED DOORS TO PREVENT PEOPLE WITH COGNITIVE DISORDERS FROM LEAVING OR GETTING LOST OR TO PROVIDE ASSISTANCE TO PEOPLE WHO REQUIRE A HIGHER LEVEL OF CARE. YOU SHOULD DISCUSS WITH THE PERSON DESIGNATED IN THIS DOCUMENT YOUR DESIRES ABOUT WHERE YOU LIVE AS YOU AGE OR IF YOUR HEALTH DECLINES. YOU HAVE THE RIGHT TO DETERMINE WHETHER TO AUTHORIZE THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE DECISIONS FOR YOU ABOUT WHERE YOU LIVE WHEN YOU ARE NO LONGER CAPABLE OF MAKING THAT DECISION. IF YOU DO NOT PROVIDE SUCH AUTHORIZATION TO THE PERSON DESIGNATED IN THIS DOCUMENT, THAT PERSON MAY NOT BE ABLE TO ASSIST YOU TO MOVE TO A MORE SUPPORTIVE LIVING ARRANGEMENT WITHOUT OBTAINING APPROVAL THROUGH A JUDICIAL PROCESS.

7. 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.

8. 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, ADVANCED PRACTICE REGISTERED NURSE, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

9. 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.

10. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

11. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

12. YOU MAY REQUEST THAT THE NEVADA SECRETARY OF STATE ELECTRONICALLY STORE WITH THE NEVADA LOCKBOX A COPY OF THIS DOCUMENT TO ALLOW ACCESS BY AN AUTHORIZED PROVIDER OF HEALTH CARE AS DEFINED IN NRS 629.031.

Section 1. Designation of Health-Care Agent and Personal Representative

I, ALEXA NICOLE FIELD, do hereby designate and appoint the person named below as my attorney-in-fact and as the guardian of my person to make heath care decisions for me as authorized in this document. "Agent," "health-care agent," and "attorney-in-fact" are used interchangeably in this document to refer to the health-care agent and any alternate serving under this instrument. I hereby designate the health-care agent, including each alternate designated herein, as my "personal representative" for purposes of HIPAA:
(*Unless the person is also your spouse, legal guardian, or the person most closely related to you by blood, none of the following may be designated as your agent: your treating provider of health care; an employee of your treating provider of health care; an operator of a health-care facility; an employee of an operator of a health-care facility.*)

HEATHER DONN FIELD
Address: 1282 N. Santa Barbara Drive, Minden, NV 89423
Phone number: 775-690-2431

Section 2. Designation of Alternate Agent

If my agent is unable or unwilling to act for me, then I designate the below-named alternate agent to serve as my agent as authorized in this document. All references to "my agent" refer to an alternate agent only after the immediate predecessor has failed or ceased to act:
(*You are not required to designate any alternate agent but you may do so. Any alternate agent you designate will be able to make the same decisions as the agent designated in Section 1 in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in Section 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)*

1. First Alternate Agent:

ANTHONY JAY FIELD
Address: 1282 N. Santa Barbara Drive, Minden, NV 89423
Phone number: 775-445-0075

If no named health-care agent or alternate health-care agent is available, able, and willing to serve, the desires expressed herein shall nevertheless remain in effect.

///
///
///

Section 3. Creation of Durable Power of Attorney for Health Care and Effective Date

By this document, I hereby create my Power of Attorney by appointing the person designated above, including each alternate named herein, as my agent to make health-care decisions for me.

DURABLE–This Power of Attorney shall not be affected by my subsequent incompetence, disability, or other incapacity.

[AC] **EFFECTIVE IMMEDIATELY**–This Power of Attorney will exist indefinitely from the date I execute this document.

[____] **SPRINGING POWER**–It is my intention and direction that my designated agent, and any person or entity that my designated agent may transact business with on my behalf, may rely on a written medical opinion issued by a licensed medical doctor stating that I am disabled or incapacitated and incapable of managing my affairs, and that said medical opinion shall establish whether or not I am under a disability for the purpose of establishing the authority of my designated agent to act in accordance with this Power of Attorney.

[____] **SPRINGING POWER**–It is my intention and direction that my designated agent, and any person or entity that my designated agent may transact business with on my behalf, may rely on: (1) an acknowledged written medical opinion issued by at least two licensed medical doctors stating that I am disabled or incapacitated and incapable of managing my affairs by reason of acts, physical or mental illness, progressive or intermittent physical or mental deterioration, or similar cause, and that said medical opinion shall establish whether or not I am under a disability for the purpose of establishing the authority of my designated agent to act in accordance with this Power of Attorney or (2) a court order holding me to be legally incapacitated to act on my own behalf or appointing a guardian of my person. Such incapacity shall be deemed to continue until such court order, medical opinions, or circumstances become inapplicable or have been revoked or two licensed medical doctors certify that they have examined me and have concluded that I am no longer incapacitated; an agent named in this Power of Attorney may act as my personal representative pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations, to obtain a determination of incapacity.

This Power of Attorney shall continue in force until revoked by me or until my death, whichever occurs first. I understand that revocation of this Power of Attorney will not be effective as to my agent until my agent has actual knowledge of the revocation. If my agent acts in good faith and without actual knowledge of the revocation, any act so performed, unless otherwise invalid or unenforceable, binds me and my successors in interest.

Section 4. Other Powers of Attorney

This Power of Attorney is intended to, and does, revoke any prior power of attorney for health-care matters I have previously executed. This Power of Attorney does not affect any power of attorney for financial matters.

Section 5. Nomination of Guardian

If, after the execution of this Power of Attorney, incompetency proceedings are initiated for my person, I hereby nominate as my guardian for consideration by the court my agents herein named, in the order named, to the extent it does not conflict with any designations made by me in my trust if my trust exists at such time. This shall be superseded by any nomination of a guardian made in a document that I sign after the date of this Power of Attorney. If my agent fails or ceases to act as the guardian of my person, the alternate agent(s) designated above shall serve in the order named.

On the appointment of a guardian of my person, this Power of Attorney shall terminate. The guardian shall follow any provisions contained in this Power of Attorney delineating my wishes for medical and end-of-life care.

Section 6. 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 health-care agent named above, including each alternate agent designated herein, 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; 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 my admission to any health-care facility including any skilled nursing facility.

This power and authority, and any other power and authority granted in this Power of Attorney, is subject to my wishes, and the limitations and special provisions, if any, set forth and initialed by me in this Power of Attorney.

If I have not indicated with my initials that I agree with an option that is stated in this Power of Attorney, my intent is to disagree with that option.

///

///

Section 7. Special Provisions and Limitations

In exercising the authority under this Power of Attorney, the authority of my agent is subject to the following special provisions and limitations:
(*Your 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, abortion, aversive intervention, experimental medical, biomedical, or behavioral treatment, or participation in any medical, biomedical, or behavioral research program, or any other treatment to which the principal, in this Power of Attorney, states that the agent may not consent. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for or other restrictions you wish to place on the agent's authority, you should list them in the space below. If you do not write any limitations, your agent will have the broad powers to make health-care decisions on your behalf which are set forth in this Power of Attorney, except to the extent that there are limits provided by law.)*

_____

_____

_____

Section 8. Statement of Desires as to Long-Term Care and Caregivers

With respect to my long-term care, my health-care agent is authorized to act in my best interest, as my health-care agent may determine. I specifically authorize my health-care agent to make decisions relating to my long-term care, subject to any statements in this Section that I have initialed. If I have not initialed a particular statement, any decisions related to that statement shall be made in my agent's discretion. If, after consulting with my physician, other health-care providers, and my family, my health-care agent determines that I need long-term care, my health-care agent shall have the full and unrestricted discretion to select my: physician and other health care providers; health-care facilities; caregivers; and/or long-term care facility.

[AF] I desire to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency, or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my activities of daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me.

[____] I desire to live in my home for as long as possible without regard for my medical needs, personal safety, or ability to engage in activities of daily living. My agent may arrange for a natural person, an employee of an agency, or a provider of community-based services to come into my home and provide care for me. I understand that, before I may be placed in

a facility or home other than the home in which I currently reside, a guardian must be appointed for me.

[____] It is my wish that my agent makes an appropriate determination at his or her discretion.

Additionally,

[AF] I wish 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.

Section 9. Statement of Desires as to Life-Sustaining Procedures

With respect to decisions to withhold or withdraw life-sustaining treatment, my health-care agent is authorized to act in my best interest, as my health-care agent may determine. I specifically authorize my health-care agent to make decisions relating to the withholding and/or withdrawal of life-sustaining procedures, subject to the statements in this paragraph that I have initialed. I have indicated my desires by initialing the statements below that I agree with and leaving blank the statements I disagree with. My initials by the statements that I agree with shall constitute a directive to my family and loved ones, to each health-care agent appointed hereunder, to my physicians, to my health-care providers, and to all others who may be responsible to provide medical care or make decisions related thereto. It is my intention that this directive be honored by my family, my attending physician(s), and by all other persons as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of my refusal. As provided in NRS 449.613(2), it is also my intention that this declaration serve as a declaration under the Uniform Act on Rights of the Terminally Ill under the provisions of NRS 449.535 to 449.690, inclusive, and any amendments thereto.

[____] 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.

[AF] If I am in a coma which my doctors or advanced practice registered nurses 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.)

[AF] 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.)

[AF] I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My health-care agent is to consider the relief of suffering, the preservation or restoration of functioning, and the quality of my life if it is prolonged.

[____] 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 gastrointestinal tract after all other treatment is withheld.

[_____] Even after all other treatment is withheld, I want to receive or continue receiving artificial nutrition and hydration by means other than the gastrointestinal tract and/or nasogastric tube.

[AF] If I have an incurable or terminal condition, including late-stage dementia, or illness and no reasonable hope of long-term recovery or survival, I desire my attending physician to administer any medication to alleviate suffering without regard that the medication is likely to cause addiction or reduce the extension of my life.

[_____] Other or additional statements of desires: _____

_____

_____

[_____] It is my wish that my agent makes an appropriate determination at his or her discretion.

Section 10. Power to Negate Directive

Notwithstanding anything to the contrary herein, I reserve the right to make any medical or health-care decisions for myself so long as I have sufficient mental capacity to give informed consent with respect to the particular decisions, and I reserve the right to object to treatment and to object to the withholding or stopping of treatment.

Section 11. Agent's Compensation, Expenses, and Gains

My agent shall be reimbursed for his or her reasonable out-of-pocket costs and expenses incurred in connection with his or her duties under this Power of Attorney.

My agent shall be entitled to retain an attorney and any other professional personnel necessary to carry out his or her duties and my wishes under this Power of Attorney.

Section 12. Uniform Anatomical Gift Act

Pursuant to NRS 451.500 et seq., I hereby make a gift of my physical remains pursuant to the Nevada Uniform Anatomical Act to any physician, dentist, hospital, university, clinic, or organization that can use the donated remains for:

[AF] The treatment of or therapy for illness or disease of a living human being,
[AF] Transplanting into a living human being,
[AF] Medical research,
[AF] Scientific research.

Any anatomical gift is made on the condition that all expenses associated with this gift shall be borne by the donee.

[_____] It is my wish that my agent makes an appropriate determination at his or her discretion.
[_____] I do not wish to make a gift of my physical remains.

Section 13. Disposition of Mortal Remains

Pursuant to the Affidavit Authorizing Cremation/Burial per NRS 451.024(9).

Section 14. Authorization of Autopsy

My agent shall have the power and authority to authorize an autopsy.

Section 15. Waiver of Conflict of Interest

If any health-care agent designated herein is a beneficiary of any property interest that might pass to him or her after my death, then I waive any conflict of interest in carrying out the provisions of this Power of Attorney that beneficiary may have by reason of the fact that he or she may be a beneficiary of mine.

Section 16. Challenges

If the legality of any provision of this Power of Attorney is questioned by my physician, my advanced practice registered nurse, 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 Power of Attorney must be construed and interpreted in accordance with the laws of the state of Nevada, but I request that it be honored wherever I may require medical treatment.

Section 17. Third Party Protection

A physician, health-care facility, or other provider of health care that in good faith accepts an acknowledged power of attorney for health care without actual knowledge that the signature is not genuine may rely upon the presumption that the signature is genuine.

A physician, health-care facility, or other provider of health care that in good faith accepts an acknowledged power of attorney for health care without actual knowledge that the power of attorney for health care is void, invalid, or terminated, or that the purported agent's authority is void, invalid, or terminated, may rely upon the power of attorney for health care as if the power of attorney for health care were genuine, valid, and still in effect, and the agent's authority was genuine, valid, and still in effect.

A physician, health-care facility, or other provider of health care that in good faith accepts an acknowledged power of attorney for health care is not subject to civil or criminal liability or

discipline for unprofessional conduct for giving effect to a declaration contained within the power of attorney for health care or for following the direction of an agent named in the power of attorney for health care.

The agent is authorized and directed to commence enforcement proceedings, at my expense, against any third party who unreasonably fails to honor this valid Power of Attorney.

Section 18. Agent's Obligations

My agent shall make health-care decisions for me in accordance with this Power of Attorney and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

Section 19. Severability

If any part of any provision of this Power of Attorney is ruled invalid or unenforceable under applicable law, such part will be ineffective to the extent of such invalidity only, without in any way affecting the remaining parts of such provisions or the remaining provisions of this Power of Attorney.

Section 20. Governing Law

This Power of Attorney shall be governed by the laws of the state of Nevada. Further, my agent is directed to act in accordance with the laws of the state of Nevada at any time he or she may be acting on my behalf.

Section 21. Release of Information

I agree to authorize and allow the full release of information by any governmental agency, medical provider, business, creditor, or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

I further agree to authorize and allow the full release of information by any governmental agency, medical provider, business, creditor, or third party who may have information pertaining to my health care, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations, as follows:

///

///

[AF] To my parents, for any health-related purpose, if my parents are not then-acting as my agent;

[ ] To the then-acting Trustee(s) of my then-existing Trust created by me as Settlor or Grantor, for the purpose of determining my capacity as defined in the Trust instrument or by governing law;

[ ] To the then-acting trustee(s) of any trust for which I am a beneficiary, for the purpose of determining my capacity as defined in the trust instrument or by governing law;

[ ] To any partner of any partnership or limited liability company of which I am a partner or member, for the purpose of determining my capacity as defined in the governing instrument or by governing law;

[AF] To my attorney, for the purpose of determining my capacity to make lifetime gifts, to execute business and estate planning documents, and whether and to what extent a guardianship or conservatorship of my person or my estate or other protective proceeding is necessary or desirable;

///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///
///

[_____] To my guardian ad litem, for the purpose of determining whether and to what extent a guardianship or conservatorship of my person or my estate or other protective proceeding is necessary or desirable.

[_____] ALL PRECEDING INDIVIDUALS AND/OR ENTITIES

I sign my name to this Durable Power of Attorney for Health Care on this 30th day of September, 2021, at Carson City, Nevada. I understand the full importance of this document and I am emotionally and mentally competent to execute it. This document constitutes an affidavit of the declarations made herein and, in compliance with NRS 53.045 (which permits unsworn declarations to serve as an affidavit without a notary), I declare under penalty of perjury that the forgoing is true and correct.

A. Field

ALEXA NICOLE FIELD

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

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

On this 30 day of September, 2021, before me, Dale Ann Luzzi, personally appeared ALEXA NICOLE FIELD, 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 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.

DALE ANN LUZZI
NOTARY PUBLIC
STATE OF NEVADA
No. 19-1705-5 My Appt. Exp. Mar. 20, 2023

Luzzi

NOTARY PUBLIC

COPIES: You should retain an executed copy of this document and give one to your health-care agent. This Power of Attorney should be available so a copy may be given to your providers of health care.

IMPORTANT INFORMATION FOR AGENT

My agent is reminded of his or her duties as outlined by the applicable law (NRS 162A.700, et seq.) including but not limited to the duty to act in accordance with my reasonable expectations, in my best interest, in good faith, and only within the authority granted in this Power of Attorney.