DOUGLAS COUNTY, NV
Rec:$40.00
Total:$40.00
HERITAGE LAW

2024-1006417
04/05/2024 03:49 PM
Pgs=11

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SHAWNYNE GARREN, RECORDER

APN# 1320-29-113-007

Recording Requested by/Mail to:

Name: HERITAGE LAW

Address: 1625 SR-88, STE 304

City/State/Zip: MINDEN, NV 89423

Mail Tax Statements to:

Name: CRAIG E. STETLER, SUCC. TTEE, et al

Address: PO BOX 653

City/State/Zip: ALTA, CA 95701

CERTIFICATION OF TRUST: GARY AND GLORIA STETLER FAMILY TRUST, DATED MARCH 20, 2001

Title of Document (required)

Please complete the Affirmation Statement below:

EX. 2 – CERTIFICATION OF TRUST, PARAGRAPH 3 MEDICAL RECORD INFORMATION

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) ☐ **Military Discharge** – NRS 419.020 (2)

☒ **Other** NRS 444A.220 (state specific law)

-OR-

EX. 1 – REDACTED DEATH CERTIFICATE

☒ I the undersigned hereby affirm the attached document, including any exhibits, hereby submitted for recording does NOT contain the personal information of any person(s). (Per NRS 239B.030)

Signature

DANIELLE CHRISTENSON

Printed Name

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

_____

_____

_____.

Certification of Trust

for the Gary and Gloria Stetler Family Trust,

dated March 20, 2001, and any amendments thereto

Pursuant to Nevada Revised Statutes Title 13, Chapter 164.400 et al., this Certification of Trust is signed by the currently acting Co-Trustees of the *Gary and Gloria Stetler Family Trust, dated March 20, 2001*, and any amendments thereto, who declare:

1. The Grantors and Trustees of the trust are GARY EDWARD STETLER and GLORIA JEAN STETLER.

2. Grantor GLORIA JEAN STETLER passed away on February 13, 2024. A redacted color copy of the Nevada Certificate of Death for GLORIA JEAN STETLER is attached as **Exhibit 1** and is incorporated herein by this reference. A certified Nevada Certificate of Death is available for inspection upon request.

3. Grantor GARY EDWARD STETLER has Dementia and, more recently, Dr. Garrett Schwartz of Renown Medical Center, completed a five-page assessment in which GARY EDWARD STETLER's diagnosis is stated as, among other physical limitations/conditions, "Mild vascular Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety" with respect to his mental condition. The assessment was delivered to the nominated Successor Co-Trustees, CRAIG E. STETLER and JULIE LYN HOPKINS, on the same date of its completion (February 20, 2024). A true and correct copy of the assessment dated February 20, 2024, is attached as **Exhibit 2** and is incorporated herein by this reference.

4. Article Three, "Trustee Succession while Both of Us Are Alive," at Section (b), "Successor Trustee during Incapacity," provides that upon or during the incapacity of a Grantor, the following serve as successor Trustee in the order named:

   CRAIG E. STETLER and JULIY LYN HOPKINS, jointly, then

   Or Either One Individually.

5. Accordingly, the nominated Successor Co-Trustees, CRAIG E. STETLER and JULIE LYN HOPKINS, jointly, ascend to the office of Successor Co-Trustee pursuant to the terms of Article Three of the trust.

6. The successor Co-Trustee(s) of the trust upon the incapacity and/or death a Grantor(s) is/are:

   CRAIG E. STETLER and JULIE LYN HOPKINS, jointly

8. Title to assets held in the trust during the surviving Grantor's incapacity and remaining lifetime will be titled as:

   Craig E. Stetler and Julie Lyn Hopkins, Co-Trustees of the Gary and Gloria Stetler Family Trust, dated March 20, 2001, and any amendments thereto.

9. The tax identification number of the trust is the Social Security number of GARY EDWARD STETLER.

10. An alternative description will be effective to title assets in the name of the trust or to designate the trust as a beneficiary if the description includes the name of at least one Co-Trustee, any reference indicating that property is being held in a fiduciary capacity, and the date of the trust.

11. Excerpts from the trust document that establishes the trust, designate the Co-Trustees, and set forth the powers of the Co-Trustees will be provided upon request. The powers of the Co-Trustees include the power to acquire, sell, assign, convey, pledge, encumber, lease, borrow, manage, and deal with real and personal property interests.

12. The terms of the trust provide that a third party may rely upon this Certification of Trust as evidence of the existence of the trust and is specifically relieved of any obligation to inquire into the terms of this trust or the authority of the Trustee, or to see to the application that the Co-Trustees make of funds or other property received by the Co-Trustees.

13. The trust has not been revoked, modified, or amended in any way that would cause the representations in this *Certification of Trust* to be incorrect.

14. **Pursuant to NRS 239B.030(4), the undersigned affirm that any certified copy, xerox copy, or .pdf of the Nevada Certificate of Death of GLORIA JEAN STETLER, Deceased, does contain the social security number of a person.**

15. The signatures on this document are those of the currently serving Co-Trustees of the trust.

16. We declare under penalty of perjury that the foregoing statements are true and correct and that the trust is in full force and effect as of the date of this *Certification of Trust.*

DATED: April 3, 2024.

CRAIG E. STETLER,
Co-Trustee during Incapacity of Surviving Grantor
GARY EDWARD STETLER

JULIE LYN HOPKINS,
Co-Trustee during Incapacity of Surviving Grantor
GARY EDWARD STETLER

STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

This document was subscribed and sworn to before me, a Notary Public, on April 3, 2024, by CRAIG E. STETLER as Co-Trustee, and JULIE LYN HOPKINS as Co-Trustee.

Notary Public

MICHELLE ANDRA GIBBONS
Notary Public - State of Nevada
Appointment Recorded in Douglas County
No: 21-1975-05 - Expires January 4, 2025

EXHIBIT 1

Gary and Gloria Stetler Family Trust,
dated March 20, 2001, and any amendments thereto

Color Copy, Nevada Certificate of Death, GLORIA JEAN STETLER

STATE OF NEVADA
CERTIFICATION OF VITAL RECORD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
VITAL STATISTICS

CASE FILE NO. 4397939

CERTIFICATE OF DEATH

2024003481
STATE FILE NUMBER

TYPE OR PRINT IN PERMANENT BLACK INK

DECEDENT

1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX)		2. DATE OF DEATH (Mo/Day/Year)	3a. COUNTY OF DEATH
Gloria Jean	STETLER	February 13, 2024	Washoe

3b. CITY, TOWN, OR LOCATION OF DEATH	3c. HOSPITAL OR OTHER INSTITUTION (Name (If not other, give street and number)	3d. If Hosp or Inst, indicate DOA, OP/Emer. Rm, Inpatient(Specify)	4. SEX
Reno	Renown Regional Medical Center	Inpatient	Female

5. RACE (Specify)	6. Hispanic Origin? Specify No - Non-Hispanic	7a. AGE-Last Birthday (Years)	7b. UNDER 1 YEAR MOS / DAYS	7c. UNDER 1 DAY HOURS / MINS	8. DATE OF BIRTH (Mo/Day/Yr)
[redacted]	No - Non-Hispanic	79			February 02, 1945

9a. STATE OF BIRTH (If not US/CA, name country)	9b. CITIZEN OF WHAT COUNTRY	10. EDUCATION	11. MARITAL STATUS (Specify)	12. USUAL OCCUPATION (Give Kind of Work Done During Most of Time Spent in This Occupation)
Nevada	UNITED STATES	14	Married	[redacted] STETLER

13. SOCIAL SECURITY NUMBER	14a. USUAL OCCUPATION (Give Kind of Work Done During Most of	14b. KIND OF BUSINESS OR INDUSTRY	Ever in US Armed Forces?
[redacted]	[redacted]	[redacted]	No

15a. RESIDENCE - STATE	15b. COUNTY	15c. CITY, TOWN OR LOCATION	15d. STREET AND NUMBER	15e. INSIDE CITY LIMITS (Specify Yes or No)
Nevada	Douglas	Minden	1765 Lantana Drive	Yes

DEATH OCCURRED IN INSTITUTION SEE HANDBOOK REGARDING COMPLETION OF RESIDENCE ITEMS

PARENTS

16. FATHER/PARENT - NAME (First Middle Last Suffix)	17. MOTHER/PARENT - NAME (First Middle Last Suffix)
[redacted]	[redacted]

18a. INFORMANT - NAME (Type or Print)	18b. MAILING ADDRESS (Street or R.F.D. No, City or Town, State, Zip)
Craig STETLER	1765 Lantana Drive Minden, Nevada 89423

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)	19b. CEMETERY OR CREMATORY - NAME	19c. LOCATION City or Town State
Cremation	Fitzhenry's Crematory	Carson City Nevada 89701

20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such)	20b. FUNERAL DIRECTOR LICENSE NUMBER	20c. NAME AND ADDRESS OF FACILITY
NORMA M FINKES SIGNATURE AUTHENTICATED	FD987	Fitzhenry'S Carson Valley Funeral Home 1637 Esmeralda Place Minden NV 89423

TRADE CALL

TRADE CALL - NAME AND ADDRESS

CERTIFIER

To Be Completed by CERTIFYING PHYSICIAN

21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.(Signature & Title)

21b. DATE SIGNED (Mo/Day/Yr)

21c. HOUR OF DEATH

21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)

To Be Completed by CORONER'S OFFICE

22a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title)

WILLIAM ABRAHAM SAGO MD SIGNATURE AUTHENTICATED

22b. DATE SIGNED (Mo/Day/Yr)	22c. HOUR OF DEATH
February 20, 2024	11:26
22d. PRONOUNCED DEAD (Mo/Day/Yr)	**22e. PRONOUNCED DEAD AT (Hour)**
February 13, 2024	11:26

23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print): William Abraham Sago MD 990 E Ninth St Reno, NV 89512

23b. LICENSE NUMBER: 22060

REGISTRAR

24a. REGISTRAR (Signature)	24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr)	24c. DEATH DUE TO COMMUNICABLE DISEASE
KATHERINE J SULLIVAN SIGNATURE AUTHENTICATED	February 21, 2024	YES ☐ NO ☒

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) — Interval between onset and death

PART I

(a) Complications Of Fracture Of The 12th Thoracic Vertebra

DUE TO, OR AS A CONSEQUENCE OF: — Interval between onset and death

(b) Blunt Force Injury Of The Torso

DUE TO, OR AS A CONSEQUENCE OF: — Interval between onset and death

(c) Ground Level Fall

DUE TO, OR AS A CONSEQUENCE OF: — Interval between onset and death

(d)

PART II OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part 1. Metastatic Carcinoma Of Unknown Etiology; Hypertensive Cardiovascular Disease; Chronic Obstructive Pulmonary Disease

26. AUTOPSY (Specify Yes or No)	27. WAS CASE REFERRED TO CORONER (Specify Yes or No)
No	Yes

28a. ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)	28b. DATE OF INJURY (Mo/Day/Yr)	28c. HOUR OF INJURY	28d. DESCRIBE HOW INJURY OCCURRED
ACCIDENT	February 10, 2024		Ground Level Fall

28e. INJURY AT WORK (Specify Yes or No)	28f. PLACE OF INJURY- At home, farm, street, factory, office building, etc. (Specify)	28g. LOCATION STREET OR R.F.D. No.	CITY OR TOWN	STATE
No	Residence	1765 Lantana Drive	Minden	Nevada

CERTIFIED COPY OF VITAL RECORDS

This is a true and exact reproduction of the document officially registered and placed on file in the office of the State Registrar and Vital Records.

Cody d Rinaldi
STATE REGISTRAR

DATE ISSUED: 2/22/2024

This copy is not valid unless prepared on engraved border displaying date, seal and signature of Registrar

THE GREAT SEAL OF THE STATE OF NEVADA

STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

EXHIBIT 2

Gary and Gloria Stetler Family Trust,
dated March 20, 2001, and any amendments thereto

Assessment of Dr. Garrett Schwartz, dated February 20, 2024

Renown HEALTH

Date: 02/26/24

From: CARSON VALLEY SENIOR CARE
1516 VIRGINIA RANCH RD
BLD A
GVILLE NV 89410-5794
Phone: 775-783-4823
Fax: 775-783-4806

Patient Active Problem List
Diagnosis

- Essential hypertension
- Hyperlipidemia
- Class 1 obesity
- Gout
- Prostate cancer screening
- Atypical atrial flutter (HCC)
- Chronic congestive heart failure (HCC)
- Paroxysmal A-fib (HCC)
- Obstructive sleep apnea syndrome
- Bradycardia
- Chronic anticoagulation
- Pacemaker
- Pulmonary HTN (HCC)
- Simple chronic bronchitis (HCC)
- Stage 3b chronic kidney disease (HCC)
- Tremor
- Tricuspid regurgitation
- Primary osteoarthritis of right hip
- Hepatic cyst
- Complete AV block (HCC)
- Cervical post-laminectomy syndrome
- Chronic pain
- Chronic heart failure with preserved ejection fraction (HCC)
- Chronic anemia
- Mild vascular dementia without behavioral disturbance, psychotic disturba mood disturbance, or anxiety (HCC)

Physician's Report (California)

I. FACILITY INFORMATION *(To be completed by the licensee/designee)*

NAME OF FACILITY

ADDRESS | NUMBER | STREET | CITY | ZIP CODE

TELEPHONE | FAX NUMBER | FACILITY LICENSE NUMBER

II. RESIDENT INFORMATION *(To be completed by the resident/resident's responsible person)*

NAME | BIRTHDATE | AGE

III. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION *(To be completed by the resident/resident's legal representative)*

I hereby authorize release of medical information in this report to the facility named above.

SIGNATURE OF RESIDENT AND/OR RESIDENT'S LEGAL REPRESENTATIVE | ADDRESS | DATE

PATIENT'S INFORMATION TO BE COMPLETED BY THE PHYSICIAN

NOTE TO PHYSICIAN: The person is either a resident or prospective resident of an assisted living facility. Please complete all of the information below. The information that you provide about this person is required to assist in determining whether the person is appropriate for care. This is not a skilled nursing facility.

DATE OF EXAM	SEX	HEIGHT	WEIGHT	BLOOD PRESSURE
2-26-24	male	68"	195	142/79

1. TUBERCULOSIS (TB) TEST (upon admission only)

a. DATE TB TEST GIVEN	b. DATE TB TEST READ	c. TYPE OF TB TEST	d. CHECK IF TB TEST IS:
		/	☐ POSITIVE ☐ NEGATIVE

e. RESULTS: _____ mm f. ACTION TAKEN (IF POSITIVE): _____

g. CHEST X-RAY RESULTS: _____

h. PLEASE CHECK ONE OF THE FOLLOWING: ☐ Active TB Disease ☐ Latent TB Infection ☐ No evidence of TB infection or disease

2. PRIMARY DIAGNOSIS

a. Treatment/medication (type and dosage)/equipment:

b. Can this patient manage own treatment/medication/equipment? ☐ yes ☒ no If not, what type of medical supervision is needed? Administering

3. SECONDARY DIAGNOSIS(ES)

a. Treatment/medication (type and dosage)/equipment:

b. Can this patient manage own treatment/medication/equipment? ☐ yes ☐ no If not, what type of medical supervision is needed?

4. CHECK IF APPLICABLE TO 2 OR 3 ABOVE

☒ Mild Cognitive Impairment: Refers to people whose cognitive abilities are in a "conditional state" between normal aging and dementia.

☐ Dementia: The loss of intellectual function (such as thinking, remembering, reasoning, exercising judgment and making decisions) and other cognitive functions, sufficient to interfere with an individual's ability to perform activities of daily living or to carry out social or occupational activities.

5. NEED TO MONITOR EXITS (If this patient has a diagnosis of dementia or related disorder)

This question ONLY applies if this patient has a diagnosis of dementia or related disorder. We wish to clarify the need to monitor exiting for them this patient has a diagnosis of dementia, please check one of the options below:

☑ Exiting does not present a hazard to this patient. He/she does not require additional monitoring while in the Community.

☐ Exits must be alarmed or an egress alert device, such as a WanderGuard wristband must be used. My patient is not able to leave the Community without supervision

☐ Not applicable. This patient does not have a diagnosis of dementia or related disorder.

6. CONTAGIOUS/INFECTIOUS DISEASE

a. Treatment/medication (type and dosage)/equipment:

b. Can this patient manage own treatment/medication/equipment? ☐ yes ☒ no If not, what type of medical supervision is needed?

ESKAT

7. ALLERGIES

a. Treatment/medication (type and dosage)/equipment:
b. Can this patient manage own treatment/medication/equipment? ☐ yes ☒ no If not, what type of medical supervision is needed?

8. OTHER CONDITIONS

a. Treatment/medication (type and dosage)/equipment:
b. Can this patient manage own treatment/medication/equipment? ☐ yes ☒ no If not, what type of medical supervision is needed?

9. PHYSICAL HEATH STATUS	YES	NO	ASSISTIVE DEVICE	COMMENTS
a. Auditory Impairment		X		
b. Visual Impairment	X		wears glasses	
c. Wears Dentures	X			
d. Wears Prosthesis		X		
e. Special Diet		X		
f. Substance Abuse Problem		X		
g. Use of Alcohol	X			
h. Use of Cigarettes		X		
i. Bowel Impairment		X		
j. Bladder Impairment		X		
k. Motor Impairment/Paralysis		X		
l. Requires Continuous Bed Care		X		
m. History of Skin Condition/Breakdown		X		

10. MENTAL CONDITION	YES	NO	EXPLAIN
a. Confused/Disoriented			
b. Inappropriate Behavior		X	
c. Aggressive Behavior		X	
d. Wandering Behavior		X	
e. Sundowning Behavior	X		
f. Able to follow Instructions	X		
g. Depressed		X	
h. Suicidal/Self-Abuse		X	
i. Able to Communicate Needs	X		
j. At Risk if Allowed Direct Access to Personal Hygiene Items		X	
k. Able to Leave Facility Unassisted		X	

11. CAPACITY FOR SELF-CARE	YES	NO	EXPLAIN
a. Able to Bathe Self	X		
b. Able to Dress Self	X		
c. Able to Feed Self	X		
d. Able to Care for Own Toileting Needs	X		
e. Able to Manage Own Cash Resource	X		

12. ESCORT REQUIREMENTS (check all that apply)

When leaving our Assisted Living Community, this patient:

- ☐ Should be escorted by staff due to cognitive impairment.
- ☐ Should be escorted by staff due to physical impairment.
- ☒ May be dropped off and later picked up by the Community van/car, leaving them unescorted for shopping visits, outings, appointments, etc.
- ☐ May leave independently with no escort, using public transportation or walking where desired.
- ☐ May drive his/her own vehicle.

ESKAT N

13. MEDICATION MANAGEMENT	YES	NO	EXPLAIN
a. Able to Administer Own Prescription Medications		X	
b. Able to Administer Own Injections		X	
c. Able to Perform Own Glucose Testing		X	
d. Able to Administer Own PRN Meds.			
e. Able to Administer Own Oxygen	X		
f. Able to Store Own Medications	X		

14. AMBULATORY STATUS

a. 1. This person is able to independently transfer to and from bed: ☒ Yes ☐ No

2. For purposes of a fire clearance, this person is considered: ☒ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire marshal, or to an oral instruction relating to fire danger, and/or a person who depends upon mechanical aids such as crutches, walkers, and wheelchairs.

Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered nonambulatory for the purposes of fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

b. If resident is nonambulatory, this status is based upon:

☐ Physical Condition ☐ Mental Condition ☐ Both Physical and Mental Condition

c. If resident is bedridden, check one or more of the following and describe the nature of the illness, surgery or other cause:

☐ Illness: _____

☐ Recovery from Surgery: _____

☐ Other: _____

NOTE: An illness or injury is considered temporary if it will last 14 days or less.

d. If a resident is bedridden, how long is bedridden status expected to persist?

1. _____(number of days)
2. _____ (estimated date illness or recovery is expected to end or when resident will no longer be confined to bed)
3. If illness or recovery is permanent, please explain: _____

16. HOSPICE

Is this patient receiving hospice care?

☒ No ☐ Yes If yes, specify the terminal illness: _____

16. PHYSICAL HEALTH STATUS

This patient's physical health status is: ☐ Good ☐ Fair ☒ Poor

17. COMMENTS

HAS MULTIPLE MEDICAL PROBLEMS (CRD, PACEMAKER, OSA, A. FIB, CHRONIC PAIN, DEMENTIA) BUT HAS BEEN ON STABLE MEDICAL REGIMEN.

18. PHYSICIAN SIGNATURE AND ADDRESS

PHYSICIAN'S NAME AND ADDRESS (PRINT):

Garrett Schwartz MD

TELEPHONE: 775-783-4823 FAX: 775 783 4806

LENGTH OF TIME THIS PERSON HAS BEEN YOUR PATIENT:

PHYSICIAN'S SIGNATURE: G. Schwartz DATE: 2/26/24

ESKAT

Medication Orders

ESKATON

AGE is Required

Resident: Gary Stetler	Age: 84	DOB: 1/9/40	Expected Date of Admission:
GENERAL ORDERS			**Comments/Instructions**
Resident is capable of self-administering medications?		☐ yes ☒ no	
Resident is permitted to consume alcohol?		☒ yes ☐ no	
Resident's current medications require crushing? If yes, list.		☐ yes ☒ no	
DNR Status			

ROUTINE MEDICATIONS

Medication	Strength/Dose/Route/Frequency	Qty	# Refills
Metoprolol	50mg ½ tablet 2 x day		
Eliquis	2.5 mg 1 tablet 2 x day		
Losartan	50 mg ½ tablet 1 x day		
Allopurinol	300 mg ½ tablet 1 x day		
Calcitriol	0.25 mcg 1 tablet 1 x day		
Donepezil	10 mg 1 tablet 1 x day in the evening		

PRN MEDICATIONS

Please initial next to the statement that best describes this resident:

~~AG~~	My patient can determine and clearly communicate his/her need for prescription and nonprescription PRN medication.
GT yes	My patient cannot determine his/her own need for a nonprescription PRN medication, but can communicate his/her symptoms clearly indicating a need for a nonprescription medication.
	My patient cannot determine his/her need for prescription or nonprescription PRN medication and cannot communicate his/her symptoms clearly indicating a need for a prescription or nonprescription medication. (Must contact physician before each dose is given and receive instructions.)

Medication	Strength/Dose/Route/Frequency	Symptom/Reason	Max Dose in 24°	Qty	# Refills
TYLENOL	500 mg 1 T PO Q6	prn pain			

Print Name (prescriber): ~~GARY Stetler~~ Signature: [signature] Date: _____