

Official Record

Recording requested By
HAROLD BRADLEY

Lincoln County - NV

Leslie Boucher - Recorder

Fee: \$21.00

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RPTT

Recorded By: AE

Book- 245 Page- 0458



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APN _____

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DURABLE POWER OF ATTORNEY

Title of Document

Affirmation Statement

____ I, the undersigned hereby affirm that the attached document, including any exhibits, hereby submitted for recording **does not contain** the social security number of any person or persons. (Per NRS 239B.030)

I, the undersigned hereby affirm that the attached document, including any exhibits, hereby submitted for recording **does contain** the social security number of a person or persons as required by law:

(State specific law)

Harold Bradley
Signature Title

HAROLD BRADLEY
Signature

10-22-08
Date

Grantees address and mail tax statement:

HAROLD BRADLEY
PO Box 912
CALIENTE NV 89008



**DECLARATION
and
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS**

I. DECLARATION

A. LIFE-SUSTAINING TREATMENT. If I should have an incurable and irreversible condition, that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If I am in a permanently unconscious condition from which I have no known hope of regaining awareness and where the application of life-sustaining treatment only prolongs the process of dying, I direct my attending physician to withhold or withdraw treatment that merely prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

B. NUTRITION AND HYDRATION. If this statement reflects your desires, you must initial the statement on the line provided.

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. If I have a condition stated above, I direct my physician to

AB (initials) WITHHOLD OR WITHDRAW artificial nutrition and hydration by way of the gastro-intestinal tract, except as is necessary to my comfort or to alleviate pain, after all other treatment is withheld pursuant to this declaration.

C. OTHER REQUESTS. none.

II. DURABLE POWER OF ATTORNEY FOR 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 KNOW THESE IMPORTANT FACTS:

AB



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 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.

A. DESIGNATION OF HEALTH CARE ATTORNEY-IN-FACT. I, Harold W Bradley, do hereby designate and appoint:

Attorney-in-Fact: Jeri Lynn Bradley
Address: 1963 North 550 West
Cedar City, Utah 84721
Phone: Home: (435)865-1153 Work: (435)586-0172
Relation, if any: Daughter

as my Attorney-in-Fact ("Agent") to make health care decisions for me as authorized in this document.

NOTE: Unless the person is also your spouse, legal guardian or related to you by blood, 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.

B. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. 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.

C. 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 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 4 or 6.

D. 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 restriction you wish to place on his or 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 provisions and limitations:

E. 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.

F. STATEMENT OF DESIRES. (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 compose your own statements.)

(If the statement reflects your desires, initial the line below the statement.)

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.

JB
(Initials)

G. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT. (You are not required to designate any Alternate 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 1 in the event that he or she is unable or unwilling to act as your Attorney-in-Fact. Also, if the Attorney-in-Fact designated in paragraph 1 is your spouse, his or her designation as your Attorney-in-Fact is automatically revoked by law if your marriage is dissolved.



If the person designated in paragraph 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 persons to serve in the order listed below.

FIRST ALTERNATE ATTORNEY-IN-FACT

Attorney-in-Fact: Harold Scott Bradley

Address: 370 Lakeport Drive
Spring Creek, Nevada 89815

Phone: Home: (775)738-8827 Work: (775)934-8562

H. PRIOR DESIGNATIONS REVOKED. I revoke any prior Durable Power of Attorney for Health Care.

III. GENERAL PROVISIONS

A. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.


B. SEVERABILITY. If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

C. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period in which I am unable to make such decisions.



(YOU MUST DATE AND SIGN THIS DOCUMENT)

I sign my name to this Document on this 16 day of Oct, 2008, at CALIENTE, Nevada.

Signature: 

Name: Harold W Bradley
Address: Caliente
Lincoln County
Nevada

SSN:

Birthdate: January 12, 1936

(THIS DOCUMENT WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE.)

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. 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 out following the place where the witnesses sign.)

I declare under penalty of perjury that Harold W Bradley is personally known to me, that Harold W Bradley signed or acknowledged this Document in my presence, that Harold W Bradley 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.





Witness Signature: Angelina Samson

Name: Angelina Samson
Address: PO-Box 953
Caliente, NV 89008

Date: 10-16-2008

Witness Signature: Robert S. Maxwell

Name: Robert S. Maxwell
Address: PO Box 862
Caliente NV 89008

Date: 10-16-2008

(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 Harold W Bradley by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of Harold W Bradley upon the death of Harold W Bradley under a will now existing or by operation of law.

Signature: Angelina Samson

Signature: Robert S. Maxwell

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.