APN N/A

APN _____

APN _____

LINCOLN COUNTY, NV
Rec:$37.00
Total:$37.00
KRYSTAL L. PARISH

2023-164166
03/29/2023 07:34 AM
Pgs=8 KC

00011154202301641660080083

OFFICIAL RECORD
AMY ELMER, RECORDER

Durable Power Attorney for Healthcare.

Title of Document

Affirmation Statement

KLP I, the undersigned hereby affirm that the attached document, including any exhibits, hereby submitted for recording **does not contain** the social security number, driver's license or identification card number, or any "Personal Information" (as defined by NRS 603A.040) 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, driver's license or identification card number, or any "Personal Information" (as defined by NRS 603A.040) of a person or persons as required by law: _____
(State specific law)

Krystal L Parish · POA
Signature Title

Krystal L Parish
Print

3/23/2023
Date

Grantees address and mail tax statement:

Krystal L Parish
PO Box 827
Caliente, NV 89008

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT:

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:

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.

A. DESIGNATION OF HEALTH CARE. I, David John Barnett, do hereby designate and appoint:

Agent:	David John Barnett Jr.
Address:	PO Box 471 Caliente, Nevada 89008
Phone:	Home: 7759621140 Work:775-962-5131
Relation, if any:	Son

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

NOTE: Unless the person is also your spouse, legal guardian or next of kin, none of the following may be designated as your Agent: (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 Agent 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, 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 admission to any health care facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

D. 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, or abortion. 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 restriction you wish to place on his or her 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 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 Agent is subject to the following provisions and limitations: NONE

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 Agent 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 Agent 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 Agent 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 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 Agent 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.

DJB
(Initials)

I do not want to be in Utah. I am LDS. I would like to be buried in Caliente, Nevvada where I have spent 98% of my life.

DJB
(Initials)

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.)

DJB
(Initials)

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.)

DJB
(Initials)

I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My Agent 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.

DJB, B
(Initials)

G. DESIGNATION OF ALTERNATE AGENT. (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 health care decisions as the Agent designated in paragraph 1 in the event that he or she is unable or unwilling to act as your Agent. Also, if the Agent designated in paragraph 1 is your spouse, his or her designation as your Agent is automatically revoked by law if your marriage is dissolved.

If the person designated in paragraph 1 as my Agent is unable to make health care decisions for me, then I designate the following persons to serve as my Agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below.

FIRST ALTERNATE AGENT

Agent:	Krystal L Parish
Address:	101 Keele Road PO Box 827 Caliente, Nevada 89008
Phone:	Home: 9282350269

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

I. WAIVER OF CONFLICT OF INTEREST. If my designated 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.

J. 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.

K. 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.

L. RELEASE OF INFORMATION. I agree to, authorize and allow full release of information by any government 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.

II. 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 21 day of March, 2023, at Caliente, Nevada.

Signature: David J Barnett

Name: David John Barnett
Address: Caliente
Lincoln County
Nevada
Birthdate: October 03, 1951

(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.)

(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.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(You may use acknowledgement before a Notary Public instead of the statement of witnesses.)

STATE OF NEVADA)
) ss:
COUNTY OF Lincoln)

On this 21 day of March, 2023, before me,
David John Barnett personally appeared,
_____, 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 or she 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.

NOTARY SEAL

W. CATHERINE TENNILLE
NOTARY PUBLIC • STATE OF NEVADA
Appointment Recorded in Lincoln County
No: 03-61972-11
Expires May 1, 2023

W. Catherine Tennille
Signature of Notary Public

COPIES: You should retain an executed copy of this document and give one to your Agent. The power of attorney should be available so a copy may be given to your providers of health care.