APN #_____

Recording Requested By:

Name Gary C. Porovich

Address_____

City/State/Zip_____

EUREKA COUNTY, NV
LAND-POA
Rec:$37.00
Total:$37.00
GARY C. POROVICH

2022-248073
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KATHERINE J. BOWLING, CLERK RECORDER

Power of Attorney
(Title of Document)

This page added to provide additional information required by NRS 111.312 Sections 1-2. (Additional recording fees applies)

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 OR ADVANCED PRACTICE REGISTERED NURSE 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 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.

1. DESIGNATION OF HEALTH CARE AGENT.

I, Gary C Porovich, do hereby designate and appoint:

Name: Siri R Porovich
Address: P.O. Box 757 Eureka, NV 89316
Telephone Number: 775-293-7041
Email address: —

as my agent to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your agent to make health care decisions for you. 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: (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.)

2. 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.

3. 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 name above full power and authority to:

(a) 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;

(b) to request, review and receive any information, oral or written, regarding my physical or mental health, including, without limitation, medical and hospital records;

(c) 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;

(d) and subject only to the limitations and special provisions, if any, set forth in sections 4 or 6.

4. 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 restrictions 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 Decisions, the authority of my agent is subject to the following special provisions and limitations (if you do not want to add any special limitations write NONE or draw a line through the spaces below):

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5. DURATION.

I understand that this power of attorney will exist indefinitely from the date I execute this document unless 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 to agent will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)
I wish to have this power of attorney end on the following date: _____

6. STATEMENT OF DESIRES REGARDING END OF LIFE DECISIONS.

With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make health care decisions that are consisted 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 one or more of the statements below reflects your desires, initial the box next to the statement(s).

A. 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. [_____]

B. 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. [MP]

C. 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. [_____]

D. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue to receive artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld. [_____]

E. 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. [Y.P.]

F. 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. [Y.P.]

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want and circling the answer you prefer.)

Other or Additional Statements of Desires:

_____

_____

_____

7. STATEMENT OF DESIRES CONCERNING LIVING ARRANGEMENTS

A. 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. [Y.P.]

B. 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. [X Y.P.]

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires:

_____

_____

_____

_____

8. DESIGNATION OF ALTERNATE AGENT.

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 person to serve in the order listed below:

A. First alternate agent: Stephanie Roberts
Address: P.O. Box 1151 Oakdale, CA 95361
Phone Number: 209-559-3911

B. Second alternate agent: _____
Address: _____
Phone Number: _____

9. PRIOR DESIGNATIONS REVOKED.

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

10. 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.

11. CHALLENGES.

If the legality of my 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.

12. NOMINATION OF GUARDIAN.

If, after execution of this Durable Power of Attorney for Health Care Decisions, 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.

13. 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 agents name herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care Decisions on the 19 day of May, 2022, at Eureka (city), NV (state).

Gary Porovich
Signature

GARY POROVICH
Printed Name

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF NEVADA)
Eureka) ss.
COUNTY OF ~~WASHOE~~)

On this 19 day of May, 2022, before me Michael Nunn, Notary Public, personally appeared Gary Porovich 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.

NOTARY PUBLIC in and for said County and State

MICHAEL ALLEN NUNN III
Notary Public - State of Nevada
Appointment Recorded in Eureka County
No: 21-6381-08 - Expires December 31, 2024

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. This includes requesting the Nevada Secretary of State to electronically store this document with the Nevada Lockbox to allow access by authorized providers of healthcare.

(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.)

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. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; or (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 the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal 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 health care facility or an employee of an operator of a health care facility.

Signature: _____
Print Name: Matthew Crimm
Date: 5/19/22

Residence Address:
564 3rd St.
Eureka, NV 89316

Signature: _____
Print Name: MICHAEL A MEARS
Date: 5/19/2022

Residence Address:
451 N O'Neil Ave
Eureka NV 89316

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

Signature: _____
Printed Name: Matthew Crimm

Date: 5/19/22

Signature: _____
Printed Name: MICHAEL A MEARS

Date: 5/19/2022