EUREKA COUNTY, NV
LAND-POA
Rec:$37.00
Total:$37.00
MICHAEL SCOTT LAITY

2023-249754
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KATHERINE J. BOWLING, CLERK RECORDER

DURABLE POWER OF ATTORNEY FOR FINANCIAL MATTERS

1. DESIGNATION OF AGENT.

I, Michael Duane Laity, do hereby designate and appoint:

Name: Michael Scott Laity

Telephone Number: 775.296.0499

Address: 21 Ave. F, McGill NV 89318
PO Box 151213 Ely, NV 89315

as my Agent to make decisions for me and in my name, place and stead and for my use and benefit and to exercise the powers as authorized in this document.

2. DESIGNATION OF ALTERNATE AGENT. *(You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same decisions as the agent designated above 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 my agent is unable or unwilling to act for me, then I designate the following person(s) to serve as my agent as authorized in this document, such person(s) to serve in the order listed below:

A. First Alternative Agent

Name: David Lawrence Laity

Telephone Number: 775.772 2057

Address: 5076 Cassandra way, Reno, NV 89523

B. Second Alternative Agent

Name: Tamera June Dingey

Telephone Number: 509 319 7755

Address: 2524 East Nebraska Ave, Spokane, WA 99208

3. OTHER POWERS OF ATTORNEY. This Power of Attorney is intended to, and does, revoke any prior Power of Attorney for financial matters I have previously executed.

4. NOMINATION OF GUARDIAN. If, after execution of this Power of Attorney, 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.

5. GRANT OF GENERAL AUTHORITY. I grant my agent and any successor agent(s) general authority to act for me with respect to the following subjects as defined in NRS 162A. (*INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.*)

_____ a. Real Property.
_____ b. Tangible Personal Property.
_____ c. Stocks and Bonds.
_____ d. Commodities and Options.
_____ e. Banks and Other Financial Institutions.
_____ f. Safe Deposit Boxes.
_____ g. Operation of Entity or Business.
_____ h. Insurance and Annuities.
_____ i. Estates, Trusts, and Other Beneficial Interests.
_____ j. Legal Affairs, Claims and Litigation.
_____ k. Personal Maintenance.
_____ l. Benefits from Governmental Programs or Civil or Military Service.
_____ m. Retirement Plans.
_____ n. Taxes.
nL o. **All Preceding Subjects.**

6. GRANT OF SPECIFIC AUTHORITY. My agent **MAY NOT** do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below.

(*CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.*)

_____ a. Create, amend, revoke, or terminate an inter vivos, family, living, irrevocable or revocable trust.
_____ b. Make a gift, subject to the limitations of NRS 162A and any special instructions in this power of attorney.
_____ c. Create or change rights of survivorship.
_____ d. Create or change a beneficiary designation.
_____ e. Waive my right to be a beneficiary of a joint and survivor annuity, including a

_____

survivor benefit under a retirement plan.

_____ f. Exercise fiduciary powers that I have authority to delegate.

_____ g. Disclaim or refuse an interest in property, including a power of appointment.

7. LIMITATION ON AGENT'S AUTHORITY. An agent that is not my spouse **MAY NOT** use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

8. SPECIAL INSTRUCTIONS OR OTHER OR ADDITIONAL AUTHORITY GRANTED TO AGENT.

_____

_____

9. DURABILITY AND EFFECTIVE DATE. *(INITIAL the clause(s) that applies.)*

_____ a. DURABLE. This power of attorney shall not be affected by my subsequent disability or incapacity.

_____ b. 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 designed agent to act in accordance with this Power of Attorney.

10. THIRD PARTY PROTECTION. Third parties may rely upon the validity of this power of attorney or a copy, and the representations of my agent as to all matters relating to any power granted to my agent; and no person or agency, who relies upon the representation of my agent or the authority granted by my agent, shall incur any liability to me or my estate as a result of permitting my agent to exercise any power unless a third party knows or has reason to know this power of attorney has terminated or is invalid.

11. RELEASE OF INFORMATION. I agree to, authorize and allow full release of information by any government agency, business, creditor, or third party who may have information pertaining to my assets or income, to my agent named herein.

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/ / /

/ / /

_____

12. SIGNATURE AND ACKNOWLEDGMENT. YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I sign my name to this Power of Attorney on this 13th day of December, 2021, in Eureka County, State of Nevada.

Michael Lauty
Principal

IF THE PRINCIPAL EXECUTING THIS DOCUMENT RESIDES IN A HOSPITAL, ASSISTED LIVING FACILITY OR FACILITY FOR SKILLED NURSING AT THE TIME OF EXECUTION OF THIS POWER OF ATTORNEY, A CERTIFICATION OF COMPETENCY OF THE PRINCIPAL FROM A PHYSICIAN, PSYCHOLOGIST OR PSYCHIATRIST MUST BE ATTACHED TO THIS POWER OF ATTORNEY BEFORE IT IS EXECUTED.

On this 13th day of December, 2021, before the undersigned, a Notary Public, personally appeared Michael Duane Lauty, 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.

KATHY BACON-BOWLING
Notary Public - State of Nevada
Appointment Recorded in Eureka County
No: 07-3652-8 - Expires May 11, 2023

Kathy Bacon-Bowling
Notary Public

IMPORTANT INFORMATION FOR AGENT

Agent's Duties. When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;

(2) act in good faith;

(3) do nothing beyond the authority granted in this power of attorney; and

(4) disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

(Principal's Name) by (Your Signature) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:

(1) act loyally for the principal's benefit;

(2) avoid conflicts that would impair your ability to act in the principal's best interest;

(3) act with care, competence, and diligence;

(4) keep a record of all receipts, disbursements, and transactions made on behalf of the principal;

(5) cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest; and

(6) attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest.

Termination of Agent's Authority. You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(1) death of the principal;

(2) the principal's revocation of the power of attorney or your authority;

(3) the occurrence of a termination event stated in the power of attorney;

(4) the purpose of the power of attorney is fully accomplished; or

(5) if you are married to the principal, your marriage is dissolved.

Liability of Agent. The meaning of the authority granted to you is defined in NRS 162A. If you violate NRS 162A or act outside the authority granted in this power of attorney, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

_____

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Warning to Persons 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 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, the 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 health care provider 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.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

1. DESIGNATION OF AGENT. (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.)

I, Michael Duane Laity, do hereby designate and appoint:

Name: Michael Scott Laity

Telephone Number: 775.296.0499

Address: 21 Ave F, McGill NV 89318

PO Box 151213 Ely, NV 89315

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

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 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.

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, the authority of my agent is subject to the following special provisions and limitations:

_____

5. 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.

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

6. 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.)

NO 1. 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.

ML 2. 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.)

ML 3. 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.)

ML 4. 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 gastro-intestinal tract after all other treatment is withheld.

ML 5. 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.

(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. DESIGNATION OF ALTERNATIVE AGENT. (You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 2, 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 or unwilling 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.

Name: David Lawrence Laity

Telephone Number: 775.772.2057

Address: 5076 Cassandra Way, Reno, NV 89523

Name: Tamera June Dingey

Telephone Number: 509 319 7755

Address: 2524 East Nebraska Ave, Spokane, WA 99208

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

9. 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.

10. 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 shall be construed and interpreted in accordance with the laws of the State of Nevada.

11. NOMINATION OF GUARDIAN. If, after execution of this General Durable Power of Attorney, 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.

12. 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, assets, income or care, to my Agent named herein.

I sign my name to this Durable Power of Attorney for Health Care Decisions on this 13th day of December, 2021, in Eureka County, State of Nevada.

Michael Duane Laity
Principal

IF THE PRINCIPAL EXECUTING THIS DOCUMENT RESIDES IN A HOSPITAL, ASSISTED LIVING FACILITY OR FACILITY FOR SKILLED NURSING AT THE TIME OF EXECUTION OF THIS POWER OF ATTORNEY, A CERTIFICATION OF COMPETENCY OF THE PRINCIPAL FROM A PHYSICIAN, PSYCHOLOGIST OR PSYCHIATRIST MUST BE ATTACHED TO THIS POWER OF ATTORNEY BEFORE IT IS EXECUTED.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of Nevada)
) ss.
County of Eureka)

On this 13th day of December, 2021, before the undersigned, a Notary Public, personally appeared Michael Duane Laity, 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.

KATHY BACON-BOWLING
Notary Public - State of Nevada
Appointment Recorded in Eureka County
No: 07-3652-8 - Expires May 11, 2023

Kathy Bacon-Bowling
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 community care facility or an employee of an operator of a health care facility.

Signed this 13th day of December, 2021.

(signature)

Matthew Crimm
(printed name)

564 3rd St Eureka, NV 89316
(address)

(signature)

Michael Nunn
(printed name)

300 S Spring St
(address)

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)

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.