

THIS DOCUMENT BECOMES EFFECTIVE ONLY ON INCAPACITY DEC 21 9 04 AM '01

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE
NOTICE TO PERSON EXECUTING THIS DOCUMENT**

This is an important legal document. Before executing this document you should know these important facts.

This document gives the person you designate as the attorney in fact (your agent) the power to make health care decisions for you. This power exists only as those health care decisions to which you are unable to give informed consent. The attorney in fact must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep alive.

Notwithstanding this document, you have the right to make medical and other health care decisions 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 or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any statement of your desires and limitations that you include in this document. You may state in this document any types of treatment that you do not desire for you to have. In addition, a court can take away the power of your agent to make health care decisions for you if your agent, (1) authorizes anything that is illegal, (2) acts contrary to your desires as stated in this document, or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital or other health care provider in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or for therapeutic, educational or scientific purposes, and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature or (b) acknowledged before a notary public in the state.

I certify that I have read the above notice.



Bobby Hanna
Dated: 12/14/01

STATE OF MISSISSIPPI
COUNTY OF DESOTO

On this 14th day of December, 2001, before me, a Notary Public in and for said state and county, duly commissioned and qualified, personally appeared Bobby Joe Hanna, to me known to be the person described in and who executes the foregoing instrument, and acknowledged that he executed the same as his free act and deed. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and Notarial Seal at office the day and year first above written.

Wendy Leigh Goff
Notary Public
My commission expires: JULY 7, 2005



AUSTIN LAW FIRM, P.A.
ATTORNEYS AT LAW
6928 COBBLESTONE DRIVE, SUITE 100
SOUTHAVEN, MS 38672

my Agent incurring personal financial liability for such contracts;

- E. To hire or fire medical, social service, and other support personnel responsible for my care;
- F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;
- G. To authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;
- H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for the failure to comply; and
- I. To make advance arrangements for my funeral and burial, including the purchase of a burial plot and marker, and such other related arrangements as my Agent shall deem appropriate, if I have not already done so myself.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

- A. The powers granted above do not include the following powers or are subject to the following rules or limitations:

_____ N/A

B. Organ Donor Certification.

If as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead, to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues. By checking the appropriate line below I specifically:

___ desire to donate my organs and/or tissues for transplantation.

___ desire to donate my _____

(insert specific organs and/or tissues for transplantation)

DO NOT desire to donate my organs or tissues for transplantation. This certification is executed in accordance with the Mississippi Anatomical Gift Law, Mississippi Code 1972 Annotated Sections 41-39-31 through 41-39-51.

5. PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT.

No person who relies in good faith upon any representations by my Agent or any one or more of the attorneys named in paragraph 1 above shall be liable to my, my estate, my heirs or assigns, for recognizing the Agent's authority.

6. NOMINATION OF GUARDIAN.

If a guardian or conservator of myself should for any reason be appointed, I nominate my Agent, named above to act in that capacity.

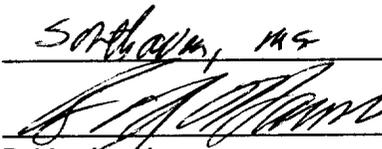
7. ADMINISTRATIVE PROVISIONS.

- A. This power of attorney is intended to be valid in any jurisdiction in which it is presented.
- B. My Agent shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.
- C. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect the others.
- D. Words in the singular in this document, including Agent, shall include the plural, and words in the masculine gender shall include the feminine, and vice versa.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this 4th day of ~~November~~ ^{December}, 2001.

My current home address is:

774 White Pine
SOUTHAVEN, MS

 Bobby Joe Hanna

**AUSTIN LAW FIRM, P.A.
ATTORNEYS AT LAW
6923 COBBLESTONE DRIVE, SUITE 1
SOUTHAVEN, MS 38672**

STATE OF Mississippi
COUNTY OF Desoto

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Witness my hand and Notarial Seal at office the day and year first above written.

Wendy Cox

Notary Public

My commission expires: July 2004

