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P3
P2

ADVANCE HEALTH CARE DIRECTIVE OF PATRICIA A. BOYLE

Notice to person executing this document

This document is a legal document. Before executing this document, you should know these important facts:

BK 98 PG 345
W.E. DAVIS CH. CLK.

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless this form limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- a. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- b. Select or discharge health-care providers and institutions;
- c. Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- d. Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

- (1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Patricia M. Leech
3720 Plum Point Dr.
Olive Branch, MS 38654
(662) 895-4415

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Carol A. Boyle
1602 Golden Oaks Loop South
Southaven, MS 38671
(662)349-8629

(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here: **NO RESTRICTIONS**

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent of my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent know to my agent.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment including artificial nutrition and hydration in accordance with the choice I have marked below:

(a) Choice Not to Prolong Life

I do not want my life to be prolonged and I direct my health care provider to withhold or withdraw treatment including artificial nutrition and hydration if both the physicians designated herein under Part 3 as primary physician and optional physician, determine either of the following: (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

(b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

PART 3

PRIMARY PHYSICIAN

(10) I designate the following physician as my primary physician:

Dr. Shankar Natarajan
2255 Germantown Rd. South
Germantown, TN 38139
901-757-0808

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

The attending physician treating me for the illness which has caused the present state.

(11) EFFECT OF COPY: A copy of this form has the same effect as the original.

(12) SIGNATURES: Sign and date the form here:

4-11-03
(Date)
1602 Golden Oaks Loop South
(Address)
Southaven, MS 38671
(City) (State)

Patricia A. Boyle
Patricia A. Boyle

(13) WITNESSES: 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 .

Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this 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 healthcare provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage or adoption, and 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.

April 11, 2003
(Date)

Mauna Bicknell
(Signature of Witness)

1265 North Point Cove
(Address)

Mauna Bicknell
(Printed name of witness)

Southaven MS 38672
(City) (State)

Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this 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 health care provider, nor an employee of a health care provider or facility.

April 11, 2003
(Date)

Christa Casey
(Signature of Witness)

5298 Russell Dr.
(Address)

Christa Casey
(Printed name of witness)

Southaven, MS 38671
(City) (State)

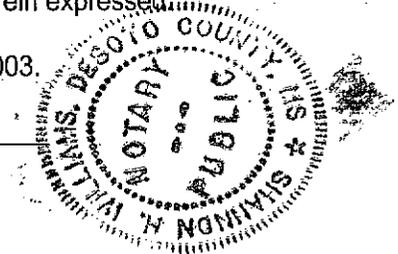
STATE OF MISSISSIPPI

COUNTY OF DESOTO

This day personally appeared before me, the undersigned authority in and for said County and State the within named, Patricia A. Boyle who acknowledged that she signed and delivered the above and foregoing Power of Attorney as her free and voluntary act and deed and for the purposes therein expressed.

Given under my hand and official seal of office, this the 11th day of April, 2003.

Shannon H. Williams
NOTARY PUBLIC



My Commission Expires:

**MISSISSIPPI STATEWIDE NOTARY PUBLIC
MY COMMISSION EXPIRES SEPT. 17, 2008
BONDED THRU STEGALL NOTARY SERVICE**