

WALLACE A. DUFFEE

POWER OF ATTORNEY

FOR HEALTH CARE

ADVANCE HEALTH-CARE DIRECTIVE

Explanation

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 the form you sign 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 agents. 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 conditions;
- (b) Select or discharge health-care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedure, 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 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 provider 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 the responsibility.

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

WALLACE A. DUFFEE
POWER OF ATTORNEY
FOR HEALTHCARE

PART I

(1) **DESIGNATION OF AGENT:** I designate the following individual as my agent to make health-care decisions for me: Cheryl Fulbright, 7435 Highway 304, Olive Branch, Mississippi 38654. Home phone number is (662) 895-6870. Cell phone number is (901) 870-3356.

OPTIONAL: 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: Bobby H. Fulbright, 7435 Highway 304, Olive Branch, Mississippi 38654. Home phone number is (662) 895-6870.

(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:

(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 unless I mark the following box. If I mark this box [], my agent's authority to make health-care decisions for me takes effect immediately.

(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 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 known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

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 in accordance with the choice I have marked below:

WAD (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relative 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:** Except as I state in the following space, 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:

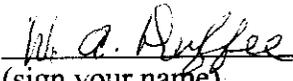
**PART 3
PRIMARY PHYSICIAN**

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

Dr. David A. Ball			
(Name of Physician)			
107 Eureka Street	Batesville	MS	38606
(Address)	(City)	(State)	(Zip Code)
(662) 563-7681			
(Phone)			

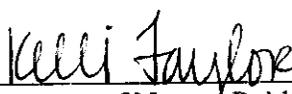
(11) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

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

3-3-05 (date)	 (sign your name)
7433 Highway 304 (address)	WALLACE A. Duffee (print your name)
Olive Branch MS 38654 (city) (state) (zip)	

STATE OF MISSISSIPPI
 COUNTY OF Tate

On this the 3rd day of March in the year 2005 before me, A NOTARY PUBLIC, appeared **WALLACE A. DUFFEE**, 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 executed it. 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.


 (Signature of Notary Public)

(NOTARY SEAL)

My Commission Expires: 7/6/07

Prepared By:

James R. Johnson, III
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 (662) 562-5234