

**ADVANCED HEALTH CARE DIRECTIVE
OF
ERICA N. PETROWSKI**

Identification. I, Erica N. Petrowski, being a competent adult of sound mind, having the capacity to make health care decisions, willfully and voluntarily declare that this is my Advanced Health Care Directive.

Dignity of Life. Death is as much a reality as birth, growth, maturity and old age; however, it should not include the indignity of useless deterioration, dependence and hopeless pain. Therefore, I have executed this Health Care Directive and this Supplement in part to relieve all of feelings of guilt or responsibility for my death. I intend that my family, any person to whom I have granted the power to provide informed consent for health care decisions on my behalf, my physicians and their medical assistants, my clergy persons, my lawyer and any medical facility caring for me and its personnel cooperate with me and with each other in carrying out my directions and in allowing me to die with dignity.

Definition of Terminal Condition. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying.

Definition of Permanent Unconscious Condition. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.

Definition of Life Sustaining Treatment. "Life-sustaining treatment" shall include, without limitation, the following: any medical or surgical treatment, procedure or intervention that uses mechanical or other artificial means, including, but not limited to, nutrition, hydration, or respiration, to sustain, restore, or replace a vital function; cardiopulmonary resuscitation, the implantation of a cardiac pacemaker, defibrillation, renal dialysis, parenteral feeding, the use of respirators or ventilators, blood transfusion, nasogastric tube use, intravenous feedings, endotracheal tube use, intubation, antibiotics, organ transplants, radiation therapy, drug treatment, or medications. "Life sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary to provide comfort, care or to alleviate pain.

Life Sustaining Treatments Withheld: Terminal Condition. If at any time I should be diagnosed in writing to be in a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.

Preparer

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Life Sustaining Treatments Withheld: Permanent Unconscious Condition. If at any time I should be diagnosed in writing to be in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.

Legal Right to Refuse Medical Treatment. In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this Directive shall be honored by my family and my physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this Directive and any other clear expressions of my desires.

Artificial Hydration and Nutrition. If I am diagnosed to be in a terminal condition or in a permanent unconscious condition, I DO NOT want to have artificially provided nutrition and hydration.

Competency. I understand the full import of this Directive, and I am emotionally and mentally capable to make the health care decisions contained in this Directive.

Additions/Deletions. I understand that before I sign this Directive, I can add to or delete from or otherwise change the wording of this Directive, and that I may add to or delete from this Directive at any time and that any changes shall be consistent with Tennessee State law or federal constitutional law to be legally valid.

Implementation. It is my wish that every part of this Directive be fully implemented. If for any reason any part is held invalid, it is my wish that the remainder of my Directive be implemented.

Supplemental Direction. Pursuant to the public policy declared in the Tennessee Right to Natural Death Act, Title 32, Chapter 11, Section 101, et seq., and to the authority granted in the Act to include other specific directions in the Health Care Directive set forth above, I declare and direct as follows:

Expansion of Directive. I am of sound mind and willfully and voluntarily make this Supplement. I do not intend that these additional specific directions revoke or in any way impair the effectiveness of any provision of the above Health Care Directive. I intend, however, to expand the circumstances under which I would want life-sustaining treatment withdrawn. If any provision of this Directive is held to be unenforceable or if the application of any provision to a particular circumstance is held invalid, such unenforceability or invalidity shall not affect the other provisions hereof.

Relief from Pain. I request care that gives me comfort and support, that facilitates my interactions with those around me and that relieves my pain and suffering. In case of severe pain, I request that drugs be administered in any necessary amount or

medical or surgical treatment be utilized calculated to relieve my pain up to and including the time of my death, regardless of side effects, even if their use may lead to permanent physical damage, addiction, or may hasten the time of my death.

Euthanasia. I do not believe in euthanasia, and even if the law has been expanded by statute or case law to include the right to die by euthanasia, I do not wish to utilize euthanasia.

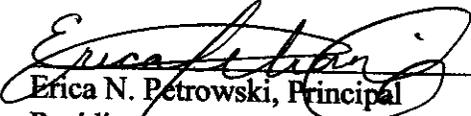
HIPAA Release Authority. I intend for my agent/proxy/surrogate to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize: any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent/proxy/surrogate, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given my agent/proxy/surrogate shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent/proxy/surrogate has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

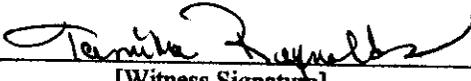
Health Care Agent. I intend that the decisions of any health care Agent that I have duly appointed to make my health care decisions be constitutionally protected as if I had made such decision(s) while competent.

Declarant Signature. This Health Care Directive and Supplement supersedes all prior "Living Wills" or similar instruments I may have signed, and I hereby revoke such prior instruments.

Directive made this 15 day of February, 2008.


Erica N. Petrowski, Principal
Residing at:
684 Hobbs
Memphis, TN 38111


[Witness Signature]
Linda Nelson
[Print Name]


[Witness Signature]
Tamika Reynolds
[Print Name]

Mississippi
State of Tennessee County of DeSoto

Subscribed, sworn to, and acknowledged before me by Erica N. Petrowski, the declarant
and subscribed and sworn to before me by Linda Nelson and
Tamika Reynolds, witnesses, this 15th day of February, 2008.

Shirley B. Amirault
signature of Notary

Shirley B. Amirault
printed name of Notary

My commission expires: March 15, 2008



Prepared by
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