

\* **Prepared by and Return to:**  
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Treadway Law Firm  
6208 Hwy. 305  
Olive Branch, MS 38654  
662-895-8170

**POWER OF ATTORNEY FOR HEALTH CARE**

204 **(1) DESIGNATION OF AGENT:** I designate the following individual as my agent to make health-care decisions for me: LOY HOLMAN ORWIG  
9779 College Rd.  
Olive Branch, MS 38654  
901-604-1471

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 alternative:

EARL ORWIG  
9779 College Rd.  
Olive Branch, MS 38654  
901-604-1467

204 **(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 including, but not limited, being put on a ventilator and being resuscitated.

204 **(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my 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.

MA **(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 included within this document, and my other wishes to the extent known to my agent. To the extent my wishes are known, 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.

MA **(5) NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate my 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.

#### INSTRUCTIONS FOR HEALTH CARE

MA **(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 my wishes as set forth below:

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 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.

MA **(7) ARTIFICIAL NUTRITION, HYDRATION, AND LIFE SUPPORT:** Artificial nutrition and hydration must be withheld and/or withdrawn in accordance with the paragraph (6). No form of artificial life support shall be administered to keep me alive.

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

MA **(9) DO NOT RESUSCITATE ORDER:** I, VIRGINIA MARGARET HOLMAN, being of sound mind request and grant permission to any and all medical professionals to refrain from resuscitating me in the event that any of the conditions described herein shall occur.

I understand that "Do not resuscitate", hereinafter referred to as "DNR", is defined to mean that in the event that my heart should stop beating, or if I should stop breathing, no medical procedure shall be instituted to restart breathing or to cause my heart to start functioning again.

I understand that this directive may be revoked by me at any time by destroying this form by any means needed to effectuate the desired result. No one other than myself can revoke this directive.

I grant permission for this form to be given to all emergency care personnel when I become incapacitated or require any type of medically procedure.

NA (10) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

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

Date: \_\_\_/\_\_\_/\_\_\_  
Signature: Virginia M Holman  
Print Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

WITNESSES:

Elizabeth Army  
Angela Miller

4945 Fogg Rd. Uxbridge, MS 38651  
6178 Shadow Oaks Cv. Olive Branch, MS 38654

STATE OF MISSISSIPPI  
COUNTY OF DESOTO

On this 23 day of May, in the year 2011, before me appeared VIRGINIA MARGARET HOLMAN, personally known to me to be the person whose name is subscribed to this instrument, and acknowledged that she executed it. I declare under the 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.



Patricia Galbraith  
NOTARY PUBLIC

My Commission Expires: 10.29.12