HEALTHCARE ADVANCE DIRECTIVE

I, _ _____, residing at _____

_____, make, constitute and

appoint _____, residing at _____

_____ (hereinafter referred to as my "Healthcare Representative"), my true and lawful attorney-in-fact to be my Health Care Representative with respect to all health care matters except the specific provisions following, upon the terms and conditions hereinafter set forth.

SPECIFIC PROVISIONS:

- IN NO CASE shall a vaccine of any kind--Covid, influenza, or any other--be administered to _____ And in NO CASE shall Remdesivir be administered to _____. And in NO CASE shall sedation and intubation for Covid treatment be undertaken unless the Healthcare Representative gives WRITTEN approval and observes the process.

- In NO CASE shall _____ be considered for hospice, end-of-life care, or "Do Not Resuscitate (DNR) unless my health care representative agrees and consents and signs a written statement to that effect.

- IF TRANSFUSION IS RECOMMENDED BY PHYSICIAN PERSONNEL, it will NOT be permitted under any circumstances unless one of the three following criteria is met:
  - Hemoglobin is less than 15, and hematocrit is less than 5
  - The Healthcare Representative in this document directs the transfusion to occur.
  - Donor blood has been obtained from someone who has never been Covid vaccinated, and never vaccinated with any mRNA type vaccine.

- In NO CASE shall I be considered for hospice, end-of-life care, or under care of a palliative physician without my Healthcare Representative's specific written instruction. And The Healthcare Representative will at all times have absolute power to discharge me from the hospital against medical advice, under any circumstances whatsoever, even if hospital personnel determined that he is dying, or it would be unsafe.

- I desire that my wishes with respect to all health care matters be carried out through the authority given to my Health Care Representative under this Health Care Power of Attorney/Advance Directive despite any contrary feelings, beliefs, or opinions of other members of my family, relatives or friends, or doctors or other hospital personnel. I have thoroughly discussed my personal preferences and desires with my Health Care Representative and his or her successor. I am fully satisfied that each will know best what I would wish, and I have the utmost faith and confidence in their respective good judgments.

- In exercising the authority herein given to my Health Care Representative, my Health Care Representative should try to discuss with me the specifics of any proposed health care decision if I am able to communicate in any manner whatsoever, even by blinking my eyes. I hereby further direct and instruct my Health Care Representative that if I am unable to give an informed consent to my medical treatment or if the physician(s) providing me with medical care determine that I lack capacity to make a particular health care decision, my Health Care Representative shall make such health care decision for me based upon any treatment choices or other desires that I have previously expressed while competent, whether under this Directive or otherwise.

My Health Care Representative is authorized to do any of the following:

- To sign on my behalf any documents necessary to carry out the authorizations described below, including waivers or releases of liabilities required by any health care provider.

- To give or withhold consent to any medical care or treatment, to revoke or change any consent previously given or implied by law for any medical care or treatment, and to arrange for my placement in or removal from any hospital, convalescent home or other health care institution.

- The rights and authority conferred on my Health Care Representative herein appointed shall include, but is by no means limited to, the right to receive my medical records while receiving treatment, the right to receive information and reports from all treating physicians, other health care professionals, health care institutions, etc., regarding proposed health care, surgery, or any other aspect of my medical treatment; the right to receive and review my medical records and information to the same extent that I am entitled to and to disclose or consent to the disclosure of my medical records to others; to contract (with all rights reserved UCC §1-308) on my behalf for any health care related service or facility (without recourse); and to hire and fire physicians, social service, and other support personnel responsible for my care.

Partnership with Doctors, Nurses & Clinical Team responsible for Care:

- Recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together if I am of sound mind and able to make my wishes known, however my decisions must be communicated to my physician by my Healthcare Proxy. If there comes a time that I am unable to make medical decisions about myself because of medications, illness or injury, I direct that the following treatment preferences be honored:

    - If I am diagnosed with COVID 19, a variant or afflicted with an ailment derived thereof, either determined through testing positive or am determined to be presumptively positive as defined by my symptoms. I intentionally and specifically reject the use of Remdesivir and the use of a ventilator as a treatment option or any other treatment method that is being utilized that is resulting in a high injury or death rate or under an Emergency Use Authorization.

- If the facility does not allow for the use of any alternative medical treatments, I direct my agent to have me discharged and placed on HOSPICE CARE as opposed to being treated with the ventilator or Remdesivir. If I am discharged, I direct that I be provided oxygen and any other necessary equipment for comfort.

- I do not consent to receiving any vaccines or MRNA injections whatsoever, while be admitted to any medical or psychiatric facility.

- In the event that new medications or treatment options are made available. I direct my Medical Power of Attorney or surrogate to conduct an independent evaluation regarding the side effects or risks associated with any new medications or treatment options prior to consenting to the administration.

- If a medical professional disregards my wishes and refuses to cooperate, I specifically request that a criminal referral be made for assault and false imprisonment, with negligent homicide if I should pass away. I have educated myself on the COVID19 pandemic and am aware that the government protocols are life threatening and that the medical establishment is knowingly causing harm. This is constructive notice to this fact.

Administrative Provisions

- This instrument is to be construed and interpreted as an "Advance Directive for Health Care" as such term is defined by state statute. In determining the rights of my Health Care Representative herein appointed, the enumeration of the specific items, rights, acts or powers set forth herein is not intended to nor does it limit, and it is not to be construed or interpreted as limiting, the specific power of my Health Care Representative to do and perform any and all acts with respect to my health care which I would be able to perform if I were competent and able to do so and as are within the bounds of authority granted by the Act.

- In the event _____shall become unable to act as my Health Care Representative hereunder for any reason whatsoever, including, but not limited to, death, incapacity, or resignation, then I do hereby make, constitute and appoint _____as successor Health Care

Representative to serve in the place of the Health Care Representative first above named.

- No person who relies in good faith upon any representations by my Health Care Representative or any successor Health Care Representative shall be liable to me, my estate, my heirs or my assigns for recognizing the Health Care Representative's authority.

- The directions of my Health Care Representative shall be binding in all respects upon all those involved in my care. My Health Care Representative and all those acting upon his or her directions shall be entitled to indemnification from my estate in connection with all claims asserted against them unless the directions given and relied on are wholly inconsistent with my intentions as expressed above.

- If a guardian of my person should be appointed for any reason, I hereby nominate my Health Care Representative _____, and as alternate _____ named above.

- I hereby revoke any prior Health Care Power of Attorney.

- This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented.

- My Health Care Representative shall not be entitled to compensation for services performed under this Health Care Power of Attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions of this Health Care Power of Attorney.

- In the event of any disagreement between my Health Care Representative and my attending physician concerning my decision-making capacity or the appropriate interpretation and application of the terms of this Health Care Power of Attorney to my course of treatment, it is my wish and desire that such disagreement be resolved in accordance with the written direction of my Health Care Representative.

- The powers delegated under this Health Care Power of Attorney are separate so that the invalidity of any one (1) or more shall not affect any others.

By this instrument, I intend to create a durable power of attorney effective upon and only during any period of incapacity in which, in the opinion of; (1) my Health Care Representative and (2) one or more other confirming physicians, and (3) I lack capacity to make a particular health care decision (i.e. "Period of Incapacity"). If I am given any sedatives, benzos or opiates, I am considered incapacitated, and all decisions for my care and treatment must be approved in writing by my Health Care Representative. The rights, powers, and authority of my Health Care Representative herein appointed shall commence and shall be in full force and effect upon any such determination as to the commencement of a Period of Incapacity, and such rights, powers and authority shall remain in full force and effect from the above-mentioned date until such time as I have regained my capacity to make such health care decision(s) or until my death, as the case may be;

PROVIDED, HOWEVER, that this Health Care Power of Attorney may be revoked by me by a written instrument duly acknowledged before a notary public or by such other manner as shall be allowed under the Act; and

PROVIDED, FURTHER, that my regaining capacity following any Period of Incapacity shall not be treated as an event causing the revocation of this Health Care Power of Attorney and this Health Care Power of Attorney shall be construed as if such Period of Incapacity never occurred.

This directive consists of 8 pages and will remain in effect until I revoke it. No other person may do so.

SIGNED on _____, 2022.

_____

_____,
Declarant

NOTARY ACKNOWLEDGEMENT
(JURAT)

STATE OF _____ §
§
COUNTY OF _____ §

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20_____, by _____ (name of signer).

(Seal)

_____
Notary Public Signature

_____
Title or Rank

_____
Serial Number, if any

My Commission Expires: _____

BEFORE ME, the undersigned authority, on this day personally appeared _____, known to me to be the Declarant whose name is subscribed to the foregoing instrument in her capacity, and, said person being by me duly sworn, the Declarant _____, declared to me in my presence that said instrument is her/his Directive to Physicians and Family or Surrogates regarding COVID 19 or any variants thereof, and that she/he had willingly and voluntarily made and executed it as her free act and deed for the purposes therein expressed.

_____

_____, Affiant

SUBSCRIBED AND ACKNOWLEDGED BEFORE ME by the said Declarant, _____, on this the __ day of , 2022.

_____

Notary Public, State of

_____

Acknowledgment for Individual