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HEALTH CARE DECLARATION

AND

HEALTH CARE POWER OF ATTORNEY

OF

GEORGE ULLRICH

I, George Ullrich, a resident of Hammond, County of Lake, State of Indiana, being at least eighteen (18) years old and of sound mind, willfully and voluntarily designate certain persons named herein to make health care decisions on my behalf, in the event of my incapacity, and make known my desires that my life or dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

I. DECLARATION UNDER INDIANA'S LIVING WILL LAW

If at any time I have an incurable injury, disease, or illness certified in writing to be a terminal condition by my attending physician, and my attending physician has determined that my death will occur within a short period of time, and the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the provision of appropriate nutrition, hydration, the administration of medication and the performance of any medical procedure necessary to provide me with comfort, care or to alleviate pain.

Without limiting the generality of the foregoing, I specifically state the following regarding certain procedures and circumstances:

A. Artificial Nutrition and Hydration. If I have lost the ability to swallow and the provision of nutrition and hydration to me can only be done by artificial means such as through intravenous, endotracheal, gastro-intestinal or nasogastric tubes and the primary

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effect of providing such artificial nutrition and hydration is to forestall my dying and not to increase my level of comfort and there is not a reasonable chance that I will recover to a meaningful, sentient life, then I do not consider such nutrition and hydration to be appropriate and I direct it to be withheld or withdrawn.

B. Antibiotics. If I contract an infection and the provision of treatments such as antibiotics might forestall my death, but not increase my level of comfort and there is not a reasonable chance that I will recover to a meaningful, sentient life, then I direct such treatments withheld or withdrawn.

C. Resuscitation. I do not want electrical or mechanical resuscitation of my heart when it has stopped beating, if there is not a reasonable chance that I will recover to a meaningful, sentient life, and in such circumstances I authorize and direct my treating physician to enter a "Do Not Resuscitate" order in my medical record.

D. Pain Medication. I authorize the use of pain medication or other treatments solely to provide me with comfort, if there is little chance that I will recover to a meaningful, sentient life, even if such treatments may lead to permanent physical or mental damage, cause addiction, or even hasten (but not intentionally cause) my death.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this Declaration be followed by my Health Care Representative and honored by my family, physician and any health care facilities in which I am a patient as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of my refusal as I have.

II. **DECLARATION IN RELATION TO HEALTH CARE IF I AM IN A COMA OR A PERSISTENT VEGETATIVE STATE**

I intend to take full advantage of Indiana's Living Will Law, however, I do not intend my right to refuse treatment to be limited to the terminal circumstances described in the Living Will Statute but also wish to exercise my Constitutional and Common Law right to refuse consent to health care, if I am in a coma or a persistent vegetative state which is reasonably concluded to be irreversible. Therefore, I authorize and direct my physician(s) to withhold or withdraw treatment as described in the foregoing section of this document, even if I am not considered to be in a terminal condition but am in a coma or persistent vegetative state which is reasonably determined to be irreversible.

I, further, authorize my Health Care Representative to direct the withholding or withdrawal of treatments in such circumstances.

III. **OTHER HEALTH CARE DIRECTIONS**

If it does not jeopardize the chance of my recovery to a meaningful, sentient life or impose an undue burden on my family, I would like to spend my last days at home rather than in a health care facility.

If any tissues are sound and would be of value as transplants to help other people, I freely give my permission for the donation of such of my bodily organs as may be of help.

If I am dying I would prefer to be under the care of a hospice program or other provider specializing in the delivery of palliative care.

IV. APPOINTMENT OF HEALTH CARE REPRESENTATIVE(S)

I hereby appoint Carlene May, presently of 7613 W. 140th Place, Apt. #1, Cedar Lake, Indiana 46303, telephone number (219) 374-8729, Social Security Number 315-30-8208, as my attorney-in-fact for health care decisions ("Health Care Representative") who is authorized to act for me in all matters of health care in accordance with I.C. §16-8-12 and I.C. §30-5. If Carlene May is unavailable or refuses to accept such appointment, I designate Elmo May, presently of 7613 W. 140th Place, Cedar Lake, Indiana 46303, telephone number (219) 374-8729, Social Security Number 311-28-2441, as my Health Care Representative.

I hereby disqualify the following persons from consenting to health care on my behalf: _____

A. When this Designation of Health Care Representative Shall be Effective:

This appointment shall become effective whenever I am unable to consent to medical treatment, as may be determined by my treating physician.

B. General Powers of my Health Care Representative.

The above-named Health Care Representative, whether the original or the successor, shall have full authority to do any lawful act for me or in my name to make all decisions related to my personal health care; including, but not limited to, the following:

1. To give consent to any medical procedures, tests or treatments, including surgery; to arrange for my hospitalization, convalescent care, hospice or home care; to summon paramedics or other emergency medical personnel and seek emergency treatment for me;

2. To request, receive and review any information regarding my personal affairs or my physical or mental health, including hospital records, and to execute any releases or other documents that may be required in order to obtain such information, and to disclose such information to

such persons, organizations, firms or corporations as my representative shall deem appropriate;

3. To employ and discharge medical personnel, including physicians, psychiatrists, dentists, nurses and therapists, for my physical, mental and emotional well-being;

4. To employ and discharge medical personnel and support personnel, to provide respite for members of my family who have taken responsibility for my care;

5. To grant releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by my representative, from all liability for damages suffered or to be suffered by me; to sign documents titled or purporting to be a "Refusal To Permit Treatment" and "Leaving Hospital Against Medical Advice", as well as any necessary waivers of, or releases from, liability required by any hospital or physician to implement my wishes regarding medical treatment or non-treatment;

6. To execute all documents required to admit me to, or release me from, any health care facility;

7. To authorize an autopsy of my remains;

8. To delegate all or part of the authority granted hereunder, if my Health Care Representative shall be reasonably unavailable to exercise such authority, to any eligible person whom I have not disqualified herein or who has not been disqualified under the provisions of I.C. 1987, §16-8-12-1, et seq;

9. To bring legal action on my behalf to enforce the provisions of this document.

C. Specific Authority of my Health Care Representative to Decide To Withhold or Withdraw Treatment

I authorize my Health Care Representative to make decisions in my best interest concerning withdrawal of health care. If at any time, based on my previously expressed preferences and diagnosis and prognosis, my Health Care Representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my Health Care Representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all

health care be discontinued or not instituted, even if death may result. This would include refusal, withdrawal, modification or changing consent to any medical procedures, tests or treatments, as well as hospitalization, convalescent care, hospice or home care which I or my representative may have previously allowed or consented to, including the refusal or withdrawal of artificial means of nutrition and hydration.

I authorize my Health Care Representative to exercise my right of privacy to make decisions regarding my medical treatment and my right to be left alone, even though the exercise of my right might hasten my death or be against conventional medical advice.

D. Guidelines for my Health Care Representative's Decisions.

My Health Care Representative must try to discuss a decision to withhold or withdraw treatment with me if I can communicate in any manner, even by blinking my eyes. However, if I am unable to communicate, my Health Care Representative may make such decision for me, after consultation with my physician or physicians and other relevant health care givers. To make such a decision, my Health Care Representative shall consider:

1. my diagnosis and prognosis;
2. the risks, benefits and burdens to me of treatment;
3. the emotional burdens on my family;
4. the financial burden on my family;
5. my statements of preference regarding health care, as expressed in this document;
6. other statements regarding health care I have made, giving most weight to my most recent statements;
7. my ethical and religious principles;
8. the opinions of appropriate family members and others, who are close to me, as to what I would want done, if I were able to express myself.

V. THE AUTHORITY OF MY HEALTH CARE REPRESENTATIVE IN RELATION TO MY HEALTH CARE DECLARATION

I intend for my Health Care Representative to be bound and guided by the provisions I have stated in my Health Care Declaration. However, I recognize that there are circumstances that I cannot anticipate and I have put my complete confidence in my Health Care Representative. Therefore, I authorize third parties, including health care providers, to rely on the decision of my Health Care Representative even if the decision of my Health Care Representative is perceived to be inconsistent with, or beyond the provisions of, my Health Care or Living Will Declarations, if I am unable to consent or to refuse treatment at the time. In the event my Health Care Representative is unable or unwilling to act during my incapacity, then the foregoing Health Care Declaration shall speak, as if I were expressing it at the time.

VI. GENERAL PROVISIONS

My Health Care Representative's decision shall be controlling notwithstanding the assertions of other members of my family.

I authorize health care providers to rely on my Health Care Representative's decisions, just as if I had made them myself, and I hereby ratify and confirm all that my Health Care Representative shall do by virtue hereof.

I authorize the delivery of this document to any physician and health care facility that may render medical treatment to me and I authorize any physician having custody of this document to release any needed medical information and to deliver any documents and information to any person as may be necessary or desirable to accomplish my intent as expressed herein.

Each health care provider and every other person who acts in good faith reliance on any direction or decision by the agent that is not clearly contrary to the terms of this

health care power of attorney form will be protected and released to the same extent as if each provider or person had dealt directly with the principal as a fully-competent person.

If a Guardian of my Person is to be appointed, I nominate my acting Health Care Representative or successor as such Guardian, whose name(s) and address(es) are set out above.

I understand the full import of this Declaration and Health Care Power of Attorney and I am executing this document as a statement of my intent this 20 day of March, 1997.

George Ulrich
GEORGE ULRICH

On the 20th day of March, 1997, the Declarant signified to me, an undersigned witness, that this Health Care Declaration and Health Care Power of Attorney was being made by the Declarant freely and voluntarily and, in my presence, the Declarant signed such Declaration and Power of Attorney and I, at the Declarant's request, and in the Declarant's presence and in the presence of the other witness hereto, signed my name in witness thereof. I, further, state that the Declarant has been personally known to me, and is believed by me to be of sound mind. I did not sign the Declarant's signature above for, or at the direction of, the Declarant. I am not a parent, spouse, or child of the Declarant, am not, to the best of my knowledge, entitled to any part of the Declarant's estate and am not directly financially responsible for the Declarant's medical care. I am competent and at least eighteen (18) years old.

Lisa K Misner
WITNESS SIGNATURE

5261 Hohman Avenue
STREET ADDRESS

Lisa K Misner
WITNESS PRINTED

Hammond, In 46322
CITY, STATE, ZIP CODE

Donna Waymire
WITNESS SIGNATURE

119 N. Indiana Ave
STREET ADDRESS

Donna Waymire
WITNESS PRINTED

Crown Point, In 46307
CITY, STATE, ZIP CODE

STATE OF INDIANA)
) SS:
COUNTY OF LAKE)

Before me, a Notary Public in and for said County and State, personally appeared George Ullrich, who acknowledged the execution of the foregoing Health Care Declaration and Health Care Power of Attorney.

WITNESS my hand and Notarial seal, this 20 day of March, 1997.

Donna Waymire
NOTARY PUBLIC
RESIDENT OF LAKE COUNTY, INDIANA

My Commission Expires: 2/15/2000

This instrument was prepared by Ruman, Clements, Tobin & Holub, P.C.
5261 Hohman Avenue, Hammond, Indiana 46320; (219) 933-7600