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STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

ARIZONA

2002 000882 THE 2002 JAN -3 AM 11:22

HEALTH CARE POWER OF ATTORNEY

RECORDER

of

WILLIAM M. KOREM

(Part 1)

KNOW ALL MEN BY THESE PRESENTS:

That I, WILLIAM M. KOREM, as principal, designate IRENE K. KOREM, whose address and telephone number is: 7121 TIMBERLANE, PRESCOTT, AZ 86305, (928) 717-0580, as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care.

This Power of Attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power of attorney during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devises and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint MARY JANE DICKEN, whose address and telephone number is 1425 ROYAL OAK CR. PRESCOTT, AZ 86305, (928) 717-0580 as my agent.

I (check one) ☑ have (☐ have not) completed and attached a Living Will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the Living Will.

I (check one) ☐ have (☑ have not) completed a prehospital medical directive pursuant to Section 36-3251 of the Arizona Revised Statutes.

This health care directive is made under Section 36-3221 of the Arizona Revised Statutes, as amended 1994, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

AUTOPSY
(Part 2)

I, WILLIAM M. KOREM, the undersigned principal, in addition to those health care directives that I have previously given in Part 1 of this Health Care Power of Attorney, I additionally wish to make known or consent to other provisions and rights under Arizona Laws in regards to my right to consent or not consent to an autopsy.

I therefore wish to reflect my desires by checking the appropriate box and initialing either of lines 1, 2, or 3.

☑ WK 1. I **do not** consent to an autopsy.

☐ _____ 2. I **consent** to an autopsy.

☐ _____ 3. My agent **may** give consent to or refuse an autopsy.

(UPC 722573-64045) (ISBN 1-57164-045-2)

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ORGAN DONATION
(Part 3)

(Under Arizona Law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental service. You may also authorize your agent to do so or a member of your family may make a gift unless you give then notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law.)

If any of the statements below reflects your desire, check and initial on the line next to that statement.

YOU DO NOT HAVE TO INITIAL ANY OF THE STATEMENTS

If you do not check and initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Arizona Law.

☑ WK I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

☐ _____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution: _____

_____ .

☐ _____ Pursuant to Arizona Law, I hereby give, effective on my death:

(check one) ☐ Any needed organ or parts (☐ The following part or organs listed: _____

_____),

for (check one) ☐ Any legally authorized purpose (☐ Transplant or therapeutic purposes only)

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

_____
Signature of Principal

Date: _____ Time: _____

Witnesses:

OFFICIAL SEAL
CHERYL LANDRY
NOTARY PUBLIC-Arizona
YAVAPAI COUNTY
My Comm. Expires Aug. 16, 2005

_____ _____
Signature of Witness Address

_____
City/State/Zip Code

_____ _____
Signature of Witness Address

_____
City/State/Zip Code

RECORDER'S OFFICE SEAL INDIANA

ACKNOWLEDGMENT
(May be used in place of Witnesses)

State of Arizona)
) ss.
County of Maricopa)

On this 12th day of December, 2001, before me, the undersigned Notary Public, personally appeared William MKorem,
known to me to be the individual who executed the foregoing instrument and acknowledge the same to be his(her) free act and deed.

My Commission Expires: 8/16/2005

_____
Notary Public

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PHYSICIAN AFFIDAVIT
(Part 4)

Before initialing any choices above you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your doctor it is a good idea to ask your physician to complete this affidavit and keep a copy for his file.

I, Dr. _____ , the undersigned Physician, whose address and telephone number is _____ _____ , have reviewed this guidance document and have discussed with _____ , the principal therein, any questions regarding the probable medical consequences of the treatment choices provided above.

This discussion with the principal occurred on _____ , _____ , at _____

I have agreed to comply with the provisions of this directive.

_____
Signature of Physician

Date: _____

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