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INDIANA POWER OF ATTORNEY FORHEALTH CARE DECISIONS AND APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I EVELYN L. GRIMMER of 1418 HARRISON AVE hereby appoint RONALD D. GARRARD of 5051 W 83rd LANE

7 219-736-7535 NONE

(home telephone number) (work telephone number)

as my attorney-in-fact to make health care decisions on my behalf whenever I am incapable of making my own health care decisions.

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I grant my attorney-in-fact the following powers in matters affecting my health care:

1- To employ or contract with servants, companions, or health care providers involved in my health care;
2- To admit or release me from a hospital or health care facility;
3- To have access to my records, including medical records;
4- To make anatomical gifts on my behalf;
5- To request an autopsy; and
6- To make plans for the disposition of my body.

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

2006 MAR 28 PM 3:35

MICHAEL A. BROWN
RECORDER

In the event the person I appoint above is unable, unwilling or unavailable to act as my attorney-in-fact, I hereby appoint:

_____ of _____

(name of successor attorney-in-fact) (address)

_____ _____

(home telephone number) (work telephone number)

as my successor attorney-in-fact.

Appointment of my Attorney-in-Fact as my Health Care Representative

In addition to the powers granted above, I appoint my attorney-in-fact as my health care representative to make decisions in my best interest concerning the consent, withdrawal or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well being. Health care also includes the providing of nutrition and hydration

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through intravenous, gastrostomy or nasogastric tubes.

If at any time, based on my previously expressed preferences and the 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be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

I, EVELYN L. GRIMMER, the principal, sign my name to this instrument this 4 day of MARCH 2006, and do
(day) (month) (year)
hereby declare to the undersigned witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

Evelyn L. Grimmer
(principal)

Subscribed and acknowledged before me by Evelyn L. Grimmer, the principal, this 4 day of March, 2006.

(notary public)

My Commission expires September 28, 2009

OFFICIAL SEAL
DEVON PETERS
NOTARY PUBLIC - INDIANA
LAKE COUNTY
My Comm. Expires Sept. 28, 2009

I, Evelyn L. Grimmer do hereby affirm that I am of sound mind and in complete control of all my faculties and senses and thoroughly understand the contents of this document and set-forth my signature as affirmation of this statement. I further declare that no person shall ever deem this document void and without merit, without my individual con sent, nor will I be coerced by anyone (family-friends, etc) to nullify or make void this declaration of my rights under the law.

Signed: Evelyn L. Grimmer Date 3-3-06

I duly affirm that I fully understand the import of this declaration.

Signed Evelyn L. Grimmer Date 3-3-06

City, County, and State of Residence Dyer, In, 46311 Lake County

Witness [signature] Date 03-03-06

Witness [signature] Date 3-3-06

STATE OF INDIANA, COUNTY OF Lake ss:

This instrument was acknowledged before me on this 3rd day of March 2006.

[signature]
Notary Public

Notary Public
Title (and Rank)

My comission expires September 28, 2009

OFFICIAL SEAL
DEVON PETERS
NOTARY PUBLIC – INDIANA
LAKE COUNTY
My Comm. Expires Sept. 28, 2009

Prescribed by the
State Board of Accounts
(2005)

County form 170

Declaration

This form is to be signed by the preparer of a document and recorded with each document in accordance with IC 36-2-7.5-5(a).

I, the undersigned preparer of the attached document, in accordance with IC 36-2-7.5, do hereby affirm under the penalties of perjury:

1. I have reviewed the attached document for the purpose of identifying and, to the extent permitted by law, redacting all Social Security number in attached document.
2. I have redacted, to the extent permitted by law, each Social Security number in the attached document.

I, undersigned, affirm under the penalties of perjury, that the foregoing declarations are true.

Ron D. Gerhard
Signature of Declarant

RON D. GERHARD
Printed Name of Declarant