EXHIBIT A

Family History

Due to difficulty in obtaining information required on the State of California death certificate, the following memorandum for this essential data is provided; (Names and birth date should agree with insurance policies and other legal documents.)

First _______________ Middle _____________
Last Name ___________________________
Sex ___________ Date of Birth ____________
Race _______ Hispanic or Spanish Decent ____
City of Birth ____________ State of Birth ____
Father's First Name ____________________
Father's Last Name _____________________
Father's State or Country of Birth __________
Mother's First Name ____________________
Mother's Maiden Name __________________
Mother's State or Country of Birth __________
Marital Status (Married/Widow/Divorce/Single)
Maiden Name of Spouse __________________
Social Security # _______________________
Primary Occupation/Job Title (If retired, what was your occupation) __________________
Primary Employer ______________________
Type of Industry or Business _____________
(If Homemaker, Yrs in Occupation still required)
Years of Formal Education Completed ________
Residence Address ______________________
City ________________ County ____________
State _________ Zip _____________________
Number of Years in Residence County ________
Name of Next of Kin _____________________
Relationship ___________________________
Address ______________________________
City _______________ State _____________
Zip __________ Telephone _______________
Doctor ________________________________
Address _________________ City __________
Doctor's Telephone ______________________
Children's Married Names & Cities of Residence
____
____
____
____

Brothers & Sisters Names & Cities of Residence
____
____
____
____

# of Grandchildren ___ Great grandchildren ___
Other Relatives:
____
____
____

Additional Information

I have been a resident of my city of last residence since ________. I have belonged to the following lodges or Clubs in what capacity
____
____
____
____

I was a veteran of WWI, WWII, Korea, Vietnam, Other ___________________________
In the Army, Navy, Air Force, Marines, Merchant Marines (1941-45), National Guard (1941-46, 50-55, 64-75)
My Serial Number is ____________________
Last Rank was _________________________
Date and Place Discharged ________________
My discharge papers are located
____
My choice of disposition is;
Burial ____ Entombment ____ Cremation _____
The name and address of the Cemetery for Burial
____
____
If cremation, the disposition of ashes are to be
____
____
I wish to have a traditional service at
______________________________ Church;
A Chapel Service at _____________________;
A service and then cremation ______________
A memorial service only to be held at
____
____
The clergy or religious affiliation I would prefer
____
Funeral Director _________________________

Attorney's Name ________________________
Address ______________________________
____
Telephone # ___________________________
My Telephone # _________________________

Signature______________________________

Date _________________________________

EXHIBIT B

LAST WILL AND TESTAMENT
OF

I, ____________________ of (County Name) ______________________, California, declare that this is my Will. I revoke all prior Wills and Codicils.

ARTICLE ONE

I. DECLARATIONS

A. I am married to ______________________________ and all references in this Will to my spouse are to him/her.

B. I have the following children by this marriage:

____

C. I have deliberately made provision for all of my heirs only in and through the FAMILY TRUST referred to in paragraph A of Article II of this Will, and on a contingent basis as provided in paragraph B of Article II of this Will.

D. I intend by this Will to Dispose only of my interest in our community property that is not held in the FAMILY TRUST, plus any separate property that may be in my probate estate at my death. Any reference in this Will to the residue of my estate shall not refer to any property or interests held in the _____________ FAMLY TRUST. I do not exercise any power of appointment I may Hold.

E. I have neither entered into a contract to make Wills nor entered into a contract not to Revoke Wills, and the similarity of the provisions of this Will to the provision of the Will of my spouse, executed by my spouse on the same date as this Will, shall not be construed as evidence of any such contract.

ARTICLE TWO

II. GIFTS

A. I leave the residue of my estate to the TRUSTEE(S) of the __________________ FAMILY TRUST. The residue of my estate shall be added to the TRUST and held , administered and distributed according to the terms of that TRUST and any amendments properly prepared and executed prior to my death. It is my intent to not create a separate TRUST by this Will, nor to subject the ________________FAMILY TRUST or the property added to it by this Will, to the jurisdiction of the Probate Court.

B. If the above disposition is inoperative in whole or in part, whether because the ___________ FAMILY TRUST fails for any reason or has been revoked, I incorporate by reference the terms of the FAMILY TRUST and any amendment properly prepared and executed prior

to my death, and I leave the residue of my estate to the TRUSTEE(S) of the FAMILY TRUST, to be held administered and distributed according to its terms.

ARTICLE THREE

III EXECUTERS

A. I nominate my spouse , ______________________________ ,to serve as EXECUTER of this Will. If she, for any reason , fails to qualify or ceases to act as EXECUTOR, I nominate the following persons as Successor EXECUTOR(S) of this Will to serve without bond, individually (severally) or jointly as indicated in the order in which they are listed:

B. A Successor EXECUTOR shall be replaced upon his or her death, incapacity, or resignation and the next Successor EXECUTOR in the order named above shall replace and succeed him or her as the Successor EXECUTOR and shall carry out the terms and provision of this Will.

C. Reference in this Will to my EXECUTOR include any personal representative of my estate.

D. In addition to any powers and elective rights conferred by statute or federal law, or by other provisions of this Will, I grant my EXECUTOR the authority to administer my estate under any procedure for informal or unsupervised administration, or any other available procedure for avoidance of administration or reduction of its burdens.

ARTICLE FOUR

IV. GENERAL PROVISIONS

A. If any Beneficiary, devise, or legatee under this Will, or any legal heir of mine, or person claming under any of them , shall attempt to contest this Will or any TRUST or beneficial interest created by it, or attack or seek to impair or invalidate any of these provisions, or conspire with or voluntarily assist anyone attempting to do any of those things, in that event I bequeath to each such person One Dollar ($ 1.00) only and all other legacies, bequest and devises, or interest given under this Will to that person shall be forfeited and shall augment proportionately the shares of my Estate going under this Will to such of my devises, legates and Beneficiaries as shall not have participated in such acts or proceeding in accordance with the provisions of this Will.

B. I direct my EXECUTOR to pay all of my debts (except mortgages, TRUST Deeds and other liens against specific property), burial expense, and expenses of my last illness. The decision of my EXECUTOR to pay any of these debts shall be final and binding upon all persons interested in my estate.

C. If any part of my Will is held to be void, invalid or inoperative, I direct that the remainder of my Will shall be carried in to effects as thought that part was never in my Will.

EXHIBIT B

D. In the event that my spouse predeceases me and any of my children haven not attained the age of eighteen(18) years, I nominate the person named below as the GUARDIAN of the person and of the estate to be taken by this Will, and / or the FAMILY TRUST, of each such minor child until such child attains eighteen (18) Years of age. I nominate the following person(s) to act or serve as a GUARDIAN:

I subscribe my name to this Will this ______________________________
Month, Day, Year

of__________________ County, California.

The Testator, ____ on the date last above written, declared to us that the above instrument, consisting 3 pages, including this page, is his Will and requested us to acts as witnesses to it. Each of us at his request now signs as a witness in the presence of the Testator and in the presence of each other. Each of us observed the signing by the Testator and the signing by each other. Each of us knows that each signature appearing hereon is true signature of the person who signed.

____

Witness Signature Date Address

____

Print Name City, State, Zip

____

Witness Signature Date Address

____

Print Name City, State, Zip

EXHIBIT C

DURABLE POWER OF ATTORNEY
UNIFORM STATUTORY FORM POWER OF ATTORNEY
(California Civil Code section 2475)

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT (CALIFORNIA CIVIL CODE SECTIONS 2475-2499.5, INCLUSIVE), IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOU.
YOU MAY REVOKE THIS POWER OF ATTORNEY LATER IF YOU WISH TO DO SO.

I, _______________________ appoint whose address is_____________________________
_______________________ as my AGENT (Attorney-in-fact). If ___________________ is unable, unwilling or ceases in any way to act as my AGENT, I appoint the following person(s) to serve individually (severally) or jointly as indicated in the order listed as Successor AGENT(S):

A Successor AGENT shall be replaced upon his or her death, incapacity, or resignation and the next Successor AGENT in the order named above shall replace and succeed him or her as Successor AGENT. These AGENTS are to act for me in any lawful way with respect to the following initialed subjects:

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL TTIE LINE MARKED WITH AN (N) AND IGNORE THE LINES RELATING TO THE OTHER POWERS.

TO GRANT ONE OR MORE, BUT FEWER THAN ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY. BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

INITIAL

-----------(A) Real Property Transactions.
-----------(B) Tangible Personal Property Transactions.
-----------(C) Stock and Bond Transactions
-----------(D) Commodity and Option Transactions.
-----------(E) Banking and other Financial Institution Transactions.
-----------(F) Business Operating Transactions.
-----------(H) Estate, Trust, and other Beneficiary Transactions.
-----------(1) Claims and Litigation.
-----------(1) Personal and Family Maintenance.
-----------(K) Benefits from Social Security, Medicare, Medicaid, or other Governmental Programs, or civil or military service.
-----------(L) Retirement Plan Transactions.
-----------(M) Tax matters.
-----------(N) ALL OF THE POWERS LISTED ABOVE
YOU NEED NOT TO INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N)

EXHIBIT C

SPECIAL INSTRUCTIONS:

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

____

____

UNLESS YOU DIRECT OTHERWISE ABOVE, THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

This power of attorney will continue to be effective even though I become incapacitated.

CROSS OUT THE PRECEDING SENTENCE IF YOU DO NOT WANT THIS POWER OF ATTORNEY TO CONTINUE IF YOU BECOME INCAPACITATED.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party has actual knowledge of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed this____________________ day of _________________ .19________

____

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF CALIFORNIA COUNTY OF _________________
On___________________________ before me, ____
Name, Title of Officer

personally appeared _______ personally known to me OR________ proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument, and acknowledged to me that he executed the same in his authorized capacity, and that by his signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

____
Signature or Notary

EXHIBIT D

STATUTORY FORM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(California Civil Code Section 2500)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT, WHICH IS AUTHORIZED BY THE KEENE HEALTH CARE AGENT ACT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY IN FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUNMNT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION AT THE TIME, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT. SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO NOT DESIRE. IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT (1) AUTHORIZES ANYTHING THAT IS ILLEGAL, (2) ACTS CONTRARY TO YOUR KNOWN DESIRES, OR (3) WHERE YOUR DESIRES ARE NOT KNOWN, DOES ANYTHING THAT IS CLEARLY CONTRARY TO YOUR BEST INTERESTS.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY NOTIFYING YOUR AGENT OR YOUR TREATING DOCTOR, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT OR EXHIBIT "A", THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO (1) AUTHORIZE AN AUTOPSY, (2) DONATE YOUR BODY OR PARTS THEREOF FOR TRANSPLANT OR

EXHIBIT D

THERAPEUTIC OR EDUCATIONAL OR SCIENTIFIC PURPOSES, AND (3) DIRECT THE DISPOSITION OF YOUR REMAINS.

THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

YOU SHOULD CAREFULLY READ AND FOLLOW THE WITNESSING PROCEDURE DESCRIBED AT THE END OF THIS FORM. THIS DOCUMENT WILL NOT BE VALID UNLESS YOU COMPLY WITH THE WITNESSING PROCEDURE.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD OBTAIN COMPETENT LEGAL ADVICE.

YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH CARE. EITHER KEEP THIS DOCUMENT WHERE IT IS IMMEDIATELY AVAILABLE TO YOUR AGENT AND ALTERNATE AGENTS OR GIVE EACH OF THEM AN EXECUTED COPY OF TIES DOCUMENT. YOU MAY ALSO WANT TO GIVE YOUR DOCTOR AN EXECUTED COPY OF THIS DOCUMENT.

DO NOT USE THIS FORM IF YOU ARE A CONSERVATEE UNDER THE LANTERMANPETRIS-SHORT ACT AND YOU WANT TO APPOINT YOUR CONSERVATOR AS YOUR AGENT. YOU CAN DO THAT ONLY IF THE APPOINTMENT DOCUMENT INCLUDES THE APPROVAL OF YOUR AGENT HAVING DURABLE POWER OF ATTORNEY (ATTORNEY-IN-FACT)

1. DESIGNATION OF HEALTH CARE AGENT. I, _________________________do hereby designate and appoint_________________________ who currently resides at_____________ as my attorney-in-fact (AGENT) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decisions" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. I hereby revoke any prior durable power of-attorney for health care.

2. NAMING OF SUCCESSOR AGENTS. In the event that_________________________________ is unable or unwilling to serve as my attorney-in-fact to make health care decisions for me, I designate and appoint the following person(s) to serve individually (severally) or jointly as indicated in the order listed as Successor AGENT(S):

3. REPLACEMENT OF SUCCESSOR AGENTS. A Successor AGENT shall be replaced upon his or her death, incapacity, or resignation and the next Successor AGENT in the order named above shall replace and succeed him or her as Successor AGENT.

4. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care under Sections 2430 to 2443 inclusive, of the California Civil Code. This power of attorney is authorized by the Keene Health Care Act and shall be construed in accordance with the provisions of Sections 2500 to 2506, inclusive, of the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

EXHIBIT D

5. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my AGENT full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my AGENT shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my AGENT, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

6. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. In exercising the authority under this durable power of attorney for health care, my AGENT shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

A. Statement of desires concerning life prolonging care, treatment, services, and procedures:

(1) I do not want my life prolonged by life-sustaining treatment provided or continued if there is no possibility of recovery as certified by two physicians not related by blood or marriage to me or any Trustee or beneficiary. Additional statements of desires, special provisions and limitations can be found in Exhibit "A" which is attached to this document.

B. Additional statement of desires, special provisions, and limitations:

(1) My AGENT shall exercise this power of attorney in accordance with my expressed desires made known to my AGENT by the attached Exhibit "A". Before acting, my AGENT shall make all attempts to communicate with me regarding my desires. Should Exhibit "A" not be attached and my desires be unknown to my AGENT, he or she shall act in my best interests.

7. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my AGENT has the power and authority to do all of the following:

A. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

B. Execute on my behalf any releases or other documents necessary to release the above records.

C. Consent to the disclosure of medical or other relevant information.

8. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my AGENT is authorized by this document to make, my AGENT has the power and authority to execute on my behalf all of the following:

A. Documents tilled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice".

B. Any necessary waiver or release from liability required by a hospital or physician.

C. Documents purporting to be an "Informed Consent".

EXHIBIT D

9. AUTOPSY; ANATOMICAL GIFTS; DISPOSITION OF REMAINS. Subject to any limitations in this document, my AGENT has the power and authority to do all of the following:

A. Authorize an autopsy under Section 7113 of the Health and Safety Code.

B. Make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5, commencing with Section 7150 of Division 7 of the Health and Safety Code).

C. Direct the disposition of my remains under Section 7100 of the Health and Safety Code.

10. NOMINATION OF CONSERVATOR OF PERSON. If a conservator of the person is to be appointed for me, I nominate ____________________ as the conservator of my person. If he/she is unable or unwilling to so act, I nominate the successor attorneys-in-fact named above as successor AGENT(S) to serve, in the order listed above, as such conservator.

11. PRIOR DESIGNATION REVOKED. I revoke any prior Durable Power of Attorney for Health Care.

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

______________________________ of ____________________ County, California.
Month, Day, Year   County Name

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY)

READ CAREFULLY BEFORE SIGNING. You can sign as a witness only if You personally know the principal or the identity of the principal is proved to you by convincing evidence.

To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

(1) An identification card or driver's license issued by any state or by a Canadian or Mexican public agency authorized to issue drivers' licenses that is current or has been issued within five years.

(2) A passport issued by the Department of State of the United States that is current or has been issued within five years.

(3) Any of the following documents if the document is current or has been issued within five years and contains a photograph, a description of the person, and bears a serial or other identifying number:

(a) A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.

EXHIBIT D

(b) An identification card issued by any branch of the armed forces of the United States.

(4) If the principal is a patient in a skilled nursing facility, a witness who is a patient advocate or ombudsman may rely upon the representations of the administrator or staff of the skilled nursing facility, or of family members that the representations provide a reasonable basis for determining the identity of the principal. Other kinds of proof of identity are not allowed.

EXHIBIT D

STATEMENT OF WITNEEES

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

______________________________	______________________________
Witness Signature	Address
______________________________	______________________________
Print Name	City, State, Zip
______________________________	______________________________
Witness Signature	Address
______________________________	______________________________
Print Name	City, State, Zip

AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.

I further declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature:______________________________

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by subdivision (f) of Section 2432 of the Civil Code.

Signature:______________________________

EXHIBIT D

EXIBIT"A"
HEALTH CARE POWER OF ATTORNEY
OF

A. **Disposition of remains**:

( ) I want my remains to be cremated. I want the ashes to be disposed of as follows:

____

( ) I want to be buried. My preferred burial site is:

cemetery

____
Address: Street, City, State

( ) See the following person or organization for more information regarding the disposition of my remains:

____
Name

____
Address Telephone

B. **Information regarding services (regardless of which preference chosen)**
( ) No Services
( ) Grave Side Services
( ) Memorial Services
( ) Religious Services
Type:____

( ) Military Services Branch:
Special
Requests: ______________________________________

____

(For example: Casket type; open or closed for services; sealed or unsealed; crypt; pallbearers; financial limitations, special song(s) or music)

C. **Limitations of special wishes with respect to the donation of organs:**
( ) Donate no organs
( ) Donate any and all usable organs
( ) Donate heart and lungs only
( ) Donate kidneys only
( ) Donate liver only
Other:____

____
Date: Month, Day, Year

EXIBIT E

DIRECTIVE TO PHYSICIANS

(Living Will)

Directive made this____
Month, Day, Year

I, ______________________, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians not related by blood or marriage to me or any Trustee or beneficiary, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not such life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

2. In the absence of my ability to give directions regarding the use of such life sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. I have been diagnosed and notified at least fourteen (14) days ago as having a terminal condition by____________________________________ M D., whose Address is

____

and whose telephone number is ____________________________________ I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.

4. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

As of the date this Directive to Physicians is signed, I reside at ________________________________
____

The declarant has been personally known to me and I believe him/her to be of sound mind.

______________________________	______________________________
Witness	Witness

EXHIBIT F
EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

PURPOSE

The Prehospital Do Not Resuscitate **(DNR)** Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services **(EMS)** providers, for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a patient's cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotonic drugs. The form does **not** affect the provision of other emergency medical care, including palliative treatment for pain, dyspnea, major hemorrage, or other medical conditions.

APPLICABILITY

This form applies only to resuscitation attempts by EMS providers in **prehospital** settings - i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. The form does not replace other written DNR orders that may be required pursuant to a long-term care facility's own policies and procedures governing CPR attempts by facility personnel. Patients should be advised that their prehospital **DNR** instruction may not be honored in other states or jurisdictions.

INSTRUCTIONS

The Prehospital Do Not Resuscitate **(DNR)** Form must be signed by the patient or by an appropriate surrogate decision maker if the patient is unable to make or communicate informed health care decisions. The surrogate should be the patient's legal representative (e.g., a Durable Power of Attorney for Health Care agent, a court-appointed conservator, a spouse or other family member) if one exists. The patient's physician must also sign the form, affirming that the patient/surrogate has given informed consent to the **DNR** instruction.

The **white copy** of the form should be retained by the patient. The completed form (or the approved wrist or neck medallion - see below) must be readily available to EMS personnel in order for the DNR instruction to be honored. Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The goldenrod copy of the form should be retained by the physician and made part of the patient's permanent medical record.

The **pink copy** of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

REVOCATION

If a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.