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ADVANCE HEALTH CARE DIRECTIVE
OF
GARY WAYNE COLEMAN, AKA
GARY COLEMAN

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker).

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

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(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health

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care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

1.1 DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Shannon Price
(name of individual you choose as agent)

[redacted]

If I revoke my first agent's authority, or if my first agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent:

[redacted] ~~Nick Barone~~ Robert Malcolm, agent
(name of individual you choose as first alternate agent)

[redacted] ~~Drive, Torrance, CA 90503~~ [redacted]
(address, city, state, zip code)

[redacted]

1.2 AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

My agent will also have the following additional powers:

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(1) To employ and discharge physicians, psychiatrists, dentists, nurses, therapists, and other professionals as my agent may deem necessary for my physical, mental, and emotional well-being.

(2) To request that aggressive medical therapy not be instituted or be discontinued as my agent believes to be in accordance with my wishes.

(3) To direct my physicians to place "No Code" and "Do Not Resuscitate" instructions on my medical chart.

(4) To consent to and to arrange for the administration of pain-relieving drugs of any type or other surgical or medical procedures calculated to relieve my pain, including (but not limited to) unconventional pain relief therapies which my agent believes may be helpful, regardless of whether their use may lead to permanent damage or even hasten (but not intentionally cause) the moment of my death; provided, however, that the benefits of such treatment outweigh any burdens such treatment may impose.

(5) 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 to be left alone might hasten my death or be against conventional medical advice, and to take appropriate legal action, if necessary, to enforce my right to privacy.

(6) To take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as is reasonable under the circumstances, including (but not limited to) obtaining round-the-clock nursing care in the event my health deteriorates to the point of requiring such care, and to respect my wish to not be hospitalized or put in a convalescent or similar home as long as it is reasonable to maintain me in my personal residence.

(7) To provide for my spiritual or religious needs.

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(8) To provide for my companionship at a time when I am disabled or otherwise unable to arrange for that companionship myself.

Shannon Price

(Add additional sheets if needed.)

1.3 WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box ☐ my agent's authority to make health care decisions for me takes effect immediately.

1.4 AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.5 AGENT'S POST-DEATH AUTHORITY: My agent is authorized to have my remains cremated, and direct disposition of my remains, except as I state here or in Part 3 of this form. Notwithstanding the foregoing, my agent will not have the power to authorize an autopsy or to donate my body or parts thereof for transplant or therapeutic or education or scientific purposes following my death.

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1.6 NOMINATION OF CONSERVATOR: If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person: Shannon Price, who resides at [redacted] and whose telephone number is [redacted]

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

2.1 END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks of treatment would outweigh the expected benefits, OR

☒ (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

No Exceptions

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2.3 OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

I request that my agent try to discuss the specifics of any proposed decision regarding my medical care or treatment with me, if I am able to communicate in any manner. If I am unable to give an informed consent to medical treatment, I want my agent to give or withhold such consent for me based upon any treatment choices that I have expressed while competent, whether under this Power of Attorney or otherwise. If my agent cannot determine the treatment choice I would make under the particular circumstances, then my agent should make the choice based on what my agent believes to be in my best interest. I give my agent full authority to give or withhold consent to any medical (including physical and psychiatric) care or treatment, to revoke or change any consent previously given or implied by law for any medical care, and to arrange for my placement in or removal from a hospital, convalescent home, hospice, or other medical facility, or to arrange for adequate home care, and to assure that all my essential needs are provided for at such facility.

Notwithstanding the foregoing, I do not wish to receive treatment that will not improve my living conditions or my health. It is my wish to live and enjoy life as long as I am able to do so, but I do not wish to receive medical treatment that will provide no benefit to me, but merely prolongs irreversible coma or delays my inevitable death. Thus, I only want treatment, including life-sustaining treatment, that offers benefits greater than the burdens it will impose. In making this decision, my agent should consider whether the treatment will relieve suffering or improve my prognosis, the intrusiveness of the treatment, the risks and side effects it involves, whether it will extend my life and, if so, what quality of life or enjoyment of life I will be able to

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have thereafter. I desire that my wishes in this regard be carried out through the authority given to my agent by this Power of Attorney despite any contrary feelings, beliefs, or opinions of other members of my family, relatives, or friends. Accordingly, if (i) two qualified physicians familiar with my condition and licensed to practice in the state of my residence or in the state in which I am located, have diagnosed and noted in my medical records that my condition is incurable, terminal, and expected to result in my death within twelve (12) months, regardless of any medical treatment which I may receive, and they have determined that I am unable to give informed consent to medical treatment; or (ii) two qualified physicians familiar with my condition and licensed to practice medicine in the state of my residence, or in the state in which I am located at the relevant time, have diagnosed that I have been in a coma for at least fifteen (15) days and that the coma is irreversible, meaning that there is no reasonable possibility of my ever regaining consciousness; then, my agent is authorized to require that medical treatment which would prolong irreversible coma or delay my inevitable death (including, by way of example only, such treatment as cardiopulmonary resuscitation, surgery, dialysis, the use of a respirator, blood transfusions, antibiotics, antiarrhythmic and pressor drugs or transplants) not be instituted, or if previously instituted, to require that it be discontinued.

If I have been in an irreversible coma as defined below for thirty (30) days or more, then my agent may also direct the procedures used to provide me with nourishment and hydration (including, for example, parenteral feeding, intravenous feedings, misting, and endotracheal or nasogastric tube use) not be instituted or, if previously instituted, to require that they be discontinued, if the two physicians mentioned above also determine that I will not experience pain as a result of the withdrawal of nourishment or hydration.

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my wishes as expressed in this Power of Attorney, including (but not limited to) any waivers or releases of liability required by any health care provider with respect to the decision of my agent to refuse any medical or psychiatric care or treatment, or to remove me from any hospital or other health care facility.

(Add additional sheets if needed.)

PART 3

DONATION OF ORGANS AT DEATH

INTENTIONALLY DELETED

PART 4

PRIMARY PHYSICIAN (OPTIONAL)

4.1 I designate the following physician as my primary physician:

Dr. Terry Hammond

[redacted]

(name of physician)

(address, city, state, zip code)

[redacted]

(phone number)

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If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address, city, state, zip code)

(phone number)

PART 5

5.1 EFFECT OF COPY: A copy of this form has the same effect as the original.

5.2 SIGNATURE: Sign and date the form here:

10/20/06
(date)

(sign your name)

[redacted]
(address)

[redacted]
(city, state, zip code)

Gary Wayne Coleman,
aka Gary Coleman
(print your name)

5.3 STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of Utah (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community

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care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness

Richard A Jepsen

(print name)

[redacted]

(address)

[redacted]

(city, state, zip code)

(signature of witness)

10-12-06

(date)

Second Witness

Sharon Anderson Monica Sage Tina Salmon

(print name)

[redacted]

(address)

[redacted]

(city, state, zip code)

Sharon Anderson

(signature of witness)

10-20-06

(date)

Monica Sage

(signature of witness)

10-12-06

(date)

Tina Salmon

(signature of witness)

10-20-06

5.4 ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of Utah that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

(signature of witness)

Sharon Anderson

(signature of witness)

Tina Salmon

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