FORM No. 15—POWER OF ATTORNEY. **HEALTH POWER OF ATTORNEY** COPYRIGHT 1990 STEVENS-NESS LAW PUBLISHING CO., PORTLAND, OR 97204

ORIGINAL

#7500 03-14-94P02:44 RCVD

Vol m94 Page 7764

KNOW ALL MEN BY THESE PRESENTS, *That I,* DANIEL B. TANNER
Daniel Bruce Tanner

have made, constituted and appointed and by these presents do make, constitute and appoint
TAMARA J. TANNER (DAUGHTER IN-PROPER) / Tamara J. Tanner
my true and lawful attorney, for me and in my name, place and stead and for my use and benefit, to

act completely, solely and entirely as my Health Care Representative ("Representative") in accordance with the State of Oregon's Advance Directive law.

In addition, I hereby authorize my Representative, Tamara J. Tanner, to make and carry out any and all decisions pertaining to my health care, including but not limited to, those critical decisions outlined in my Advance Directive, endorsed and initialled by me on February 24, 1994, and attached hereto as Exhibit 1.

giving and granting unto my said attorney full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done, as fully, to all intents and purposes, as I might or could do if personally present, hereby ratifying and confirming all that my said attorney shall lawfully do or cause to be done, by virtue hereof.

In construing this instrument and where the context so requires, the singular includes the plural.

Dated ~~Feb 22~~ 24 ~~......~~ 1994

Daniel Bruce Tanner

Tamara J. Tanner — Tamara J. Tanner

OFFICIAL SEAL
KATHRYN A. DENTON
NOTARY PUBLIC-OREGON
COMMISSION NO. 019863
MY COMMISSION EXPIRES DEC. 25, 1996

STATE OF OREGON, County of Klamath) ss.

This instrument was acknowledged before me on February 24, 1994,
by Daniel B Tanner

Kathryn A Denton
Notary Public for Oregon
My commission expires 12/25/96

POWER OF ATTORNEY
(FORM No. 15)

TO

AFTER RECORDING RETURN TO

Tamara J. Tanner
7819 Emilys Way
Greenbelt, MD 20770

NAME, ADDRESS, ZIP

SPACE RESERVED FOR RECORDER'S USE

STATE OF OREGON, } ss.
County of ....

I certify that the within instrument was received for record on the ...... day of ...., 19......, at .... o'clock .....M., and recorded in book/reel/volume No. ...., on page .... or as fee/file/instrument/microfilm/reception No. ...., Record of .... of said County.

Witness my hand and seal of County affixed.

NAME TITLE

By .... *Deputy*

NA

7765

ORIGINAL

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C (Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

Daniel Bruce Tanner
NAME

02/13/35
BIRTHDATE

Plum Ridge Care Center 1401 Campus Drive
ADDRESS

Klamath Falls, Ore. 97601

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

DBT My entire life

_____ Other period (_____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint Tamara J. Tanner (Daughter) as my health care representative. My representative's address is 7819 Emilys Way Greenbelt, MD 20770 and telephone number is 301/982-9405 202/624-7503

I appoint _____ as my alternate health care representative. My alternate's address is _____ and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. Limits. Special Conditions or Instructions: _____

INITIAL IF THIS APPLIES:

OL I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support. "Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

AD My representative MAY decide about life support for me. (If you don't initial this space, then your represenative MAY NOT decide about life support.)

3. Tube Feeding. One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

TF My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

_____
DATE

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

_____
SIGNATURE OF PERSON MAKING APPOINTMENT

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in Part B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
AK I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
AK I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
AK I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
AK I want NO life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
AK I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
AK I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
AK I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
AK I want NO life support.

5. General Instruction.

INITIAL IF THIS APPLIES:
AK I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions. That I am kept as comfortable and pain-free as possible.

(INSERT DESCRIPTION OF WHAT YOU WANT DONE.)

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:
AK I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.
_____ I have a health care power of attorney, and I REVOKE IT.
_____ I DO NOT have a health care power of attorney.

02/24/94
DATE

SIGN HERE TO GIVE INSTRUCTIONS

Daniel K. Bonner
SIGNATURE

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:
(a) Is personally known to us or has provided proof of identity;
(b) Signed or acknowledged that person's signature on this advance directive in our presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Has not appointed either of us as health care representative or alternative representative; and
(e) Is not a patient for whom either of us is attending physician.

Witnessed By:

Isidro Lopez Gomez
SIGNATURE OF WITNESS / DATE

Isidro Lopez Gomez
PRINTED NAME OF WITNESS

SIGNATURE OF WITNESS / DATE

PRINTED NAME OF WITNESS

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

Tamara J. Tanner
SIGNATURE OF HEALTH CARE REPRESENTATIVE / DATE

None
SIGNATURE OF ALTERNATE HEALTH CARE REPRESENTATIVE / DATE

Tamara J. Tanner
PRINTED NAME

PRINTED NAME

7769

Physician Services
West Excel, Inc.

2625 Crosby Avenue, Klamath Falls, Oregon 97603 • 503/885-6733 • FAX 503/883-1879

March 1, 1994

Department of Social Security

RE: TANNER, DANIEL

To Whom It May Concern:

I have had the opportunity to care for Mr. Tanner over the last two months. Initially I hospitalized him in January of 1994 for pancytopenia for which his condition gradually improved and he followed up once in the office in the interim.

Last month, in February, he was again rehospitalized with an acute upper gastrointestinal hemorrhage and presented cold, covered with melenic feces, and with a hemoglobin of 4. He was resuscitated with blood products and found to have an acute bleeding duodenal ulcer which responded to conservative treatment, and his medical condition gradually improved.

However, unfortunately, Mr. Tanner seems to suffer from a degree of anoxic brain damage secondary to the prolonged period for which he was cold and unresponsive, and with the hemoglobin of 4. Therefore, it is assumed that for an extended period of time he had decreased cerebral perfusion of oxygen and now has brain damage similar to that when people have heart attacks or for any other reasons have a prolonged period of cerebral anoxia.

He has currently been transferred from the hospital to an intermediate nursing facility. At this point, he probably has a very poor prognosis regarding any form of recovery to his prior level of activity or cognitive function. On my exam, he has lost at least 50% of his mental capabilities and it will be a matter of time to see how much of this he is able to recover.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Rande K. Short, MD

Rande K. Short, M.D.
2625 Crosby Avenue
Klamath Falls, OR 97603
Tel. (503) 883-6733 or 883-0325

RKS/hl

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Tamara J. Tanner the 14th day of March A.D., 19 94 at 2:44 o'clock P M., and duly recorded in Vol. M94, of Power of Attorney on Page 7764.

Evelyn Biehn County Clerk
By Darlene Nussbaum

FEE $30.00