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POWER OF ATTORNEY FOR HEALTH CARE

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE

NOTICE

The purpose of this Power of Attorney is to give the person you designate (your "agent") broad powers to make health care decisions for you, including power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home or other institution. This form does not impose a duty on your agent to exercise granted powers; but when powers are exercised, your agent will have to use due care to act for your benefit and in accordance with this form and keep a record of receipts, disbursements and significant actions taken as agent. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name successor agents under

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this form but not co-agents, and no Health Care Provider may be named.

Unless you expressly limit the duration of this power in the manner provided below, until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you become disabled. The powers you give your agent, your right to revoke those powers and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, 4-9 and 4-10(b) of the Illinois "Powers of Attorney for Health Care Law" of which this form is a part. That law expressly permits the use of any different form of Power of Attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

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sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.):

N/A

THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT; BUT DO NOT INITIAL MORE THAN ONE:

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I do not want my life to be prolonged, nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed _____

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW." ABSENT AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH, AND BEYOND IF ANATOMICAL GIFT, AUTOPSY OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. (X) This power of attorney shall become effective on

THE DATE HEREOF

(insert a future date or event during your lifetime, such as court determination of your disability, when you want this power to first take effect)

4. ( ) This power of attorney shall terminate on

NONE

(insert a future date or event, such as court determination of your disability, when you want this power to terminate prior to your death)

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IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH.

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5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

NONE

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

IF YOU WISH TO NAME YOUR AGENT AS GUARDIAN OF YOUR PERSON, IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY RETAINING THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT YOUR AGENT IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. STRIKE OUT PARAGRAPH 6 IF YOU DO NOT WANT YOUR AGENT TO ACT AS GUARDIAN.

6. If a guardian of my person is to be appointed, I nominate the agent acting under this Power of Attorney as such guardian, to serve without bond or security:

ROSS THOMPSON

7. I am fully informed as to all the contents of this form and understand the full import of this grant of power to my agent.

SIGNED: _____

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We certify that in our presence on the date appearing above, MARY B. THOMPSON, who cannot write, affixed her mark to the foregoing instrument and acknowledged it to be her Power of Attorney, that at her request and in her presence we have signed our names as witnesses, we also certify that the Power of Attorney was read to her in our presence before execution and she stated through head movement that she understood its provisions, and that we believe her to be of sound mind and memory.

_____ Residing at _____
(witness)

_____ Residing at _____
(witness)

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent (and successors)

I certify that the signatures of my agent (and successors) are correct.

_____
AGENT

_____
PRINCIPAL

_____
SUCCESSOR AGENT

_____
PRINCIPAL

_____
SUCCESSOR AGENT

_____
PRINCIPAL

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STATE OF ILLINOIS)
) ss.
COUNTY OF)

I, the undersigned, a Notary Public in and for the County and State aforesaid, do hereby certify that MARY B. THOMPSON, personally known to me to be the Principal who signed the foregoing instrument, appeared before me this day in person and acknowledged that she signed, sealed and delivered the said instrument, by signing her mark, as her free and voluntary act, for the uses and purposes therein set forth.

January 6, 1993
Dated:

Carol A Samartino
Notary Public

"OFFICIAL SEAL"
CAROL A. SAMARTINO
Notary Public, State of Illinois
My Commission Expires 6-19-94

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Rose Thompson
1549 N. Cicero
Chgo, IL 60651