

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

California Probate Code Section 4703(a)

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the California Natural Death 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 document, 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.

Unless you specify a shorter period in this document, this power will exist for an indefinite period of time, from the date you execute this document and, if you are unable to make health care decisions for yourself at any time, this power will continue to exist until the time when you become able to make health care decisions for yourself.

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, the document gives your agent the power after

you die to (1) authorize an autopsy, (2) donate your body parts thereof for transplant or 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.

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 this document. You may also want to give your doctor an executed copy of this document.

Initial: REG

1. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I, Ruby E. Garrison, residing at 3621 Pitcairn Way, San Jose, California 95111, intend to create a durable power of attorney for health care under Sections 4600 to 4752, inclusive, of the California Probate Code. This power of attorney shall not be affected by my subsequent incapacity.

2. DESIGNATION OF HEALTH CARE AGENT. I do hereby designate and appoint Charlotte D. Garrison Reinhard, who resides at 960 Linda Vista Avenue, San Jose, California 95126, and whose telephone number is (408) 8254-9242 as my attorney in fact (referred to in this document as my "agent") to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

3. 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 (if not inconsistent with my desires as stated in this document) otherwise made known to my agent, including, but not limited to, my desires concerning obtaining, refusing, or withdrawing life-prolonging care, treatment, services, and procedures.

4. 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.

SELECT EITHER ALTERNATIVE (A), (B), OR (C).

First Alternative:

(a) If I should have an incurable and irreversible condition that has been diagnosed by two physicians and that will result in my death within a relative short time without the administration of life-sustaining treatment or has produced an irreversible coma or persistent vegetative state, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Natural Death Act of California, to withhold or withdraw treatment, including artificially administered nutrition and hydration, that only prolongs the process of dying or the irreversible coma or persistent vegetative state and is not necessary for my comfort or to alleviate pain.

If I have diagnosed as pregnant, and that diagnosis is known to my physician, this declaration shall have no force or effect during my pregnancy.

At the same time that I am signing this durable power of attorney for health care, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

YES _____

Second Alternative:

(b) Statement of Desires Concerning Life-Prolonging Treatment, Services, and Procedures:
I do not want to receive medical treatment that, although sustaining my life, has the effect of prolonging my inevitable death if the burdens of such treatment outweigh the anticipated benefits. In making this decision, my agent shall consider the quality and duration of my remaining life if such treatment is provided or continued and the relief from pain if such treatment is withheld or withdrawn. At the same time that I am signing this durable power of attorney for health care, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

YES REB

Third Alternative:

(c) I do desire that my life be artificially prolonged under the circumstances described herein and do not want my agent to have the power to authorize an autopsy. At the same time that I am signing this durable power of attorney for health care, I am entering my initials in the space immediately below this provision to show that I have read this provision and that it reflects my desires.

YES _____

(d) Additional Statement of Desires, Special Provisions, and Limitations:

I will be expressing further wishes and desires in a document entitled "Statement of Wishes" which my agent must review to assist in making a decision.

If withholding or withdrawing nutrition and hydration will cause me to experience substantial pain or discomfort, I want to be provided with the nutrition and hydration.

By initialing in front of the words "YES", "NO", or "NEITHER" I have indicated my desires notwithstanding the preceding subparagraphs.

5. 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 that may be required in order to obtain this information; and
 - (c) Consent to the disclosure of this information.

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. When 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 titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" and;
 - (b) Any necessary waiver or release from liability required by a hospital or physician.

7. ANATOMICAL GIFTS. My agent shall have the power and authority to make a disposition or a part or parts of my body under the Uniform Anatomical Gift Act.

8. DISPOSITION OF REMAINS. My agent shall have the power and authority to direct the disposition of my remains according to my agent's discretion.

9. AUTHORIZATION OF AUTOPSY. My agent shall have the power and authority to authorize an autopsy.

10. ALTERNATE AGENT. If Charlotte D. Garrison Reinhard, is not available or becomes ineligible to act as agent to make health care decisions for me, or if I revoke Charlotte D. Garrison Reinhard's appointment or authority to act as agent to make health care decisions for me, then I designate the following person to serve as my agent to make health care decisions for me as authorized in this document:

Name: Brandy Garrison
Address: 3621 Pitcairn Way, San Jose, California 95111
Telephone Number: (408) 225-9350

11. NOMINATION OF CONSERVATOR OF PERSON. If a conservator of the person is to be appointed for me, I nominate the following individuals to serve as co-conservator of the person:

Name: Charlotte D. Garrison Reinhard
Address: 960 Linda Vista Avenue, San Jose, California 95111
Telephone Number: (408) 254-9242

12. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

13. ADVICE OF LAWYER OBTAINED. My lawyer has advised me concerning my rights in connection with this power of attorney and the applicable law and the consequences of signing or not signing this power of attorney. I have read the warning contained in subdivision (a) of California Probate Code Section 4703.

DATE AND SIGNATURE OF PRINCIPAL

I, Ruby E. Garrison, sign my name to this **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** on 7/21/ 1998, in the County of Santa Clara, California.

Ruby E. Garrison
Ruby E. Garrison

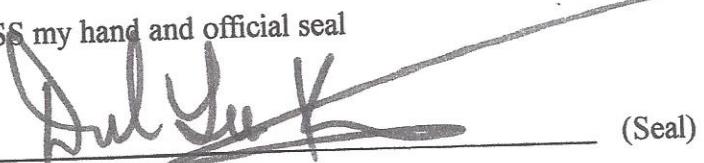
CERTIFICATE OF ACKNOWLEDGMENT

STATE OF CALIFORNIA)

COUNTY OF SANTA CLARA)

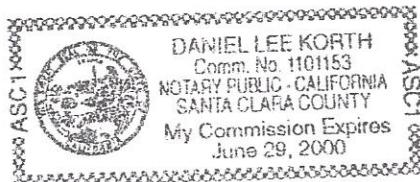
On 7/21/1998, 1998 before me, Daniel Lee Korth,
a NOTARY PUBLIC, personally appeared Ruby E. Garrison, [] personally known to me - OR
- [XX] proved to me on the basis of satisfactory evidence, to be the person whose name is subscribed
to this instrument and acknowledged that she executed it. I declare under penalty of perjury that the
person whose name is subscribed to this instrument appears to be of sound mind and under no duress,
fraud, or undue influence.

WITNESS my hand and official seal



(Seal)

Signature of Notary



**STATEMENT OF WISHES - EXHIBIT "A" TO THE HEALTH CARE
POWER OF ATTORNEY OF RUBY E. GARRISON**

A. Disposition of remains:

[] I want my remains to be cremated. I want the ashes to be disposed of as follows:

[] I have already made arrangements for my funeral.

Funeral Home:

Name

Address

[] I have not made arrangements for my funeral, but my preferred burial site is:

Cemetery

City

State

B. Information regarding services (regardless of which preference chosen)

Graveside Services? _____ [Yes / No]

Memorial Services? _____ [Yes / No]

Religious Services? _____ [Yes / No]

Type?

Military Services? _____ [Yes / No]

Branch

Special Requests:

(Casket type; open or closed for services; sealed or unsealed; vault or no vault; pallbearers; financial limitations, feelings; special song(s) or music; etc.)

C. Limitations or special wishes with respect to the donation of organs:

[] No limitations or special wishes.

[] Donate heart and lungs.

[] Donate kidneys.

[] No donation of organs.

[] Other: _____

Date: _____

Ruby E. Garrison

HEALTH CARE
POWER OF ATTORNEY

APPOINTMENT OF ATTORNEY-IN-FACT

I, Dwaine O. Garrison, do hereby designate and appoint Ruby E. Garrison who resides at 3621 Pitcairn Way, San Jose, CA. 95111, and whose telephone number is (408) 225-9350, 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 decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

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 Agent 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.

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.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

I do not want my life to be prolonged and I do not want life-sustaining treatment to be provided or continued if the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.

Any other additional statements or desires, special provisions, or limitations can be found in Exhibit "A" which is attached hereto and incorporated herein by this reference.

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:

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

2. Execute on my behalf any releases or other documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

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:

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

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

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:

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

2. 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 Part 1 of Division 7 of the Health and Safety Code).

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

DESIGNATION OF ALTERNATE AGENTS

Even though I have named one person to act as my primary agent, it is my wish that the alternates be consulted before any decision is made pursuant to this document.

If the person designated in Paragraph 1 as my agent is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or

authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

1. First Alternative Agent

Name: Charlotte D. Garrison Reinhard
Address: 960 Linda Vista Avenue
San Jose, CA. 95126
Telephone Number: (408) 254-9242

NOMINATION OF CONSERVATOR

If a conservator is to be appointed for me, I nominate the persons I have appointed to hold this Durable Power of Attorney for Health Care (in the same order of preference) to serve as the conservator of my person.

DURATION

I understand that this power of attorney will exist for seven years from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself.

RELIANCE ON PHOTOCOPIES

Any person dealing with the Attorney shall have the right to rely on a photocopy of this Durable Power of Attorney for Health Care as if it were the signed, original Durable Power of Attorney for Health Care.

PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

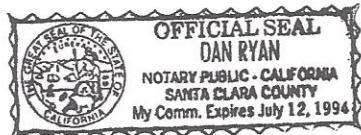
I sign my name to this Durable Power of Attorney for Health Care on April 23, 1991, in the County of Santa Clara, California.

Dwaine O. Garrison
Dwaine O. Garrison

STATE OF CALIFORNIA)
)
COUNTY OF SANTA CLARA) ss.

On April 23, 1991, before me, the undersigned, a Notary Public, in and for said County and State, personally appeared Dwaine O. Garrison known to me to be the person whose name is subscribed to this Durable Power of Attorney for health care, and acknowledged to me that he executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

WITNESS MY HAND AND OFFICIAL SEAL





NOTARY PUBLIC

EXHIBIT "A" TO HEALTH CARE POWER
OF DWAIN O. GARRISON

A. Disposition of remains:

[] I want my remains to be cremated. I want the ashes to be disposed of as follows: _____

[XX] I have already made arrangements for my funeral.

Funeral Home: OAK HILL MEMORIAL PARK

Name

SAN JOSE, CALIFORNIA

Address

Phone

[] I have not made arrangements for my funeral, but my preferred burial site is:

Cemetery

City

State

B. Information regarding services (regardless of which preference chosen)

Graveside Services? _____ (Yes/No)

Memorial Services? _____ (Yes/No)

Religious Services? _____ (Yes/No)

Type? _____

Military Services? _____ (Yes/No)

Branch? _____

Special Requests: _____

(Casket type; open or closed for services; sealed or unsealed; vault or no vault; pallbearers; financial limitations, feelings; special song(s) or music; etc.)

C. Limitations or special wishes with respect to the donation of organs:

- [] No limitations or special wishes.
- [] Donate heart and lungs.
- [] Donate kidneys.
- [] No donation of organs.
- [] Other: _____

Dwaine O. Garrison
Dwaine O. Garrison

DIRECTIVE TO PHYSICIANS

BY

DWAINE O. GARRISON

Directive made on APRIL 23, 1991.

(RE-EXECUTE FIVE YEARS FROM ABOVE DATE.)

I, Dwaine O. Garrison, 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, 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 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 life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn and 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 my 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 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. This directive shall have no force or effect five (5) years from the date filled in above.

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

 Dwaine O. Garrison residing at 3621 Pitcairn Way
San Jose, CA. 95111

The declarant, Dwaine O. Garrison, has been personally known to us and we believe him to be of sound mind.

Ken S Pasbor, residing at 189 Sylvan Way
* Signature of Witness Felton, California.


* Signature of Witness, residing at 223 Alton Way
San Jose, California.

John Ryan, residing at 6948 Howard Ct
* Signature of Witness San Jose, California.

"Natural Death Act," California Health and Safety Code,
Section 7188

*Only qualified persons may act as Witnesses.
See above Statute