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MUST HAVE DOCUMENTS

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Shelby Cnty Judge of Probate, AL
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ADVANCE DIRECTIVE & DURABLE POWER OF ATTORNEY FOR HEALTH CARE

SRIKANTH KARRA

INSTRUCTIONS FOR ADVANCE DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The advance directive and durable power of attorney for health care will print with an "Explanation" at the beginning of the document. This information is a required part of this legal document and should be included as the first page when it's printed.

Initial in ink your choice in section (7) END-OF-LIFE DECISIONS and sign and date the form. Have two witnesses sign at the end of the form where indicated. Anyone that you named as an agent or who is acting as your health care provider may not be a witness. A witness should be a "disinterested" party and must be a legal adult, at least 18 years of age. Then you need to make a trip to a notary public to have your signature notarized.

Once you've completed your advance directive and durable power of attorney for health care, you'll need to create a letter to your doctor or doctors (which can be sent along with a copy of the advance directive and durable power of attorney for health care) to request that the document become a part of your permanent medical records.

Many states have created durable power of attorney for health care forms. We prefer using the form we have created based on our experience. Many of the state forms are confusing and contain provisions you may not intend. Some state forms say that the form becomes invalid if you are a woman carrying a viable fetus, for example.

If you would like to see your state's forms, you may download them at http://www.caringinfo.org. If you do decide to use your state's forms, we recommend you complete the one provided in the program in addition to assure you will have a valid form.

Keep your original advance directive and durable power of attorney for health care in your Ultimate Protection Portfolio.

ADVANCE DIRECTIVE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

EXPLANATION

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. 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 coworker.)

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.

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 7 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 7 of this form.

Part 5 of this form lets you express an intention to donate your bodily organs and tissues following your death.

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.

POWER OF ATTORNEY FOR HEALTH CARE

1. **DESIGNATION OF AGENT:** I, **SRIKANTH KARRA**, designate the following individual as my agent to make health care decisions for me:

Name of person you choose as agent: **SUMITHRA KARRA**
5064 GREYSTONE WAY BIRMINGHAM ALABAMA 35242
(Address) (City) (State) (Zip Code)

[redacted] (Work Phone) [redacted]
(Home/Cell Phone) (Email Address)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my 1st alternate agent:

Name of person you choose as 1st alt. agent: SOWMYA KARRA
5064 GREYSTONE WAY BIRMINGHAM AL 35242
(Address) (City) (State) (Zip Code)

[redacted] [redacted]
(~~Home~~/Cell phone) (Work Phone) (Email Address)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my 2nd alternate agent:

Name of person you choose as 2nd alt. agent: _____

_____ _____ _____ _____

(Address) (City) (State) (Zip Code)

_____ _____ _____

(Home/Cell phone) (Work Phone) (Email Address)

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.

3. **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority to make health care decisions for me takes effect immediately.

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 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.

5. **AGENT'S POSTDEATH AUTHORITY:** My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here on this form:

No Organ Donation.

6. **NOMINATION OF CONSERVATOR:** If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

7. **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: **(Initial only one box)**

[✓] (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 and burdens 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.

8. **RELIEF FROM PAIN:** I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death.

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

10. **AUTHORIZATION FOR USE / RELEASE OF HEALTH INFORMATION:** I authorize any person, doctor, or organization to release or disclose protected health information to my health care agent.

11. **VALID IN ALL STATES:** This document is intended to be valid in any jurisdiction in which it is presented. If any provision is considered unenforceable, the other provisions shall remain valid and binding.

02/08/2020 — (Date)

K Srikanth — (Sign Your Name)

5064 GREYSTONE WAY
(Address)

SRIKANTH KARRA
(Print Your Name)

BIRMINGHAM
(City)

ALABAMA
(State)

State of Alabama
County of SHELBY } ss.

On this the 8th day of FEBRUARY, 2020, before me,
Day Month Year

BRAD E. SWEENEY, the undersigned Notary Public,
Name of Notary Public

personally appeared SAIKANTH KAMA,
Name(s) of Signer(s)

☐ personally known to me –**OR**–

☑ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument, and acknowledged to me that he/she/they executed the same for the purposes therein stated.

WITNESS my hand and official seal.

BRAD E. SWEENEY
My Commission Expires
February 19, 2023

Place Notary Seal/Stamp Above

Signature of Notary Public

BRAD E. SWEENEY

02/19/2023

Any Other Required Information
(Printed Name of Notary, Expiration Date, etc.)

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WITNESS STATEMENT

I declare under penalty of perjury that (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 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.

I further declare under penalty of perjury 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.

02|08|2020	P Swarna
(Date)	(Signature of Witness #1)
362 GREYSTONE GLEN CIR	SWARNA L DHEERAVATH
(Address)	(Printed Name of Witness #1)
BIRMINGHAM	AL
(City)	(State)
Feb-08-2020	AW
(Date)	(Signature of Witness #2)
362 GREYSTONE GLEN CIR	ASHOK DHEERAVATH
(Address)	(Printed Name of Witness #2)
BIRMINGHAM	ALABAMA
(City)	(State)

WALLET CARDS

Below are two copies of a wallet card containing important information regarding the agents you appointed as well as your organ donation preference. Please cut out the cards; you may wish to laminate them at a local office supply store. The cards should be kept where emergency health care personnel will find them, such as in a wallet. Your agents should have access to your signed Advance Directive and Durable Power of Attorney for Health Care document to show to the health care personnel so they can make health care decisions for you. Please make sure you give your agents a copy of the signed document, or at least let them know where they can easily locate the document in case of an emergency.

SUZEORMAN'S MUST HAVE DOCUMENTS
ADVANCED DIRECTIVE & DURABLE POWER OF ATTORNEY FOR HEALTHCARE

Attention Health Care Providers & Physicians
I, **SRIKANTH KARRA**, have an Advance Directive & Durable Power of Attorney for Health Care. Should I become incapacitated and unable to make my own health care decisions, I have appointed the following individuals to act as health care agent/proxy on my behalf:
1st Agent: **SUMITHRA KARRA - 205-617-8700**
Organ Donation: **NO**

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