NOTICE AND WARNING* TO *PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS DOCUMENT YOU SHOULD KNOW ALL THESE IMPORTANT FACTS:

- Except as you otherwise specify in this document, this document gives the person you designate is your health care proxy (the attorney-in-fact) the power to make health care decisions for you when you are no longer capable of making healthcare decisions for yourself. Your health care proxy must act consistently with your desires as stated in this document or otherwise made known. Unless you state otherwise, your health care proxy has the same authority to make decisions about your health care as you would have had.

- Your health care proxy has the power to make a broad range of health care decisions for you. The person you appoint as your health care proxy should be someone you know and trust. You should discuss this document with your health care proxy.

- Except as you otherwise specify in this document, this document gives your health care proxy the power to consent to your physician 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. 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 health care proxy 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 specify in this document any types of treatment that you do or do not desire.

- In addition, a court can take away the power of your health care proxy to make health care decisions for you if your health care proxy authorizes anything that is illegal, or acts contrary to your known desires as stated in this document.

- You have the right to revoke the authority of your health care proxy or to revoke this document entirely by notifying your health care proxy or your attending physician, hospital, or other health care provider orally or in writing of the revocation.

- This document revokes any prior durable power of attorney for health care.

- Unless you otherwise specify in this document, this document gives your health care proxy the power after you die to donate your body or parts thereof for transplant or therapeutic, educational or scientific purposes, and to direct the disposition of your remains.

- It is important that you understand the nature and range of decisions that may be made on your behalf. If there is anything in this document that you do not understand, you should ask your attorney or physician to explain it to you. You should discuss this document with your health care proxy.

- Your health care proxy 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 health care proxy and alternate health care proxy or give each of them an executed copy of this document. You also may want to give your physician an executed copy of this document.

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Shelby Cnty Judge of Probate, AL
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Initials

Appointment of Health Care Proxy

TO: My family, physicians, hospitals, nursing homes, all types of entities that provide any type of medical care, and all others concerned with my care.

I, **Jeannie Yvonne Young,** presently residing at **50 Saddle Ridge Drive Columbiana, AL 35051** and being an adult of sound mind, hereby appoint and authorize my **Son, Dennis William Polley** presently residing at **337 Saddle Ridge Drive Columbiana, AL 35051,** as my health care proxy and attorney-in-fact to act for me and in my name to make and communicate any and all decisions about or relating to my receipt or refusal to accept medical treatment, hospitalization, health care or personal care, in any situation in which, as the result of illness, disease, mental deterioration or injury, I am incapable of making or communicating a decision with respect to my treatment or care. This authorization includes the right to refuse and direct the withdrawal of medical treatment which would prolong my life, and to communicate health care decisions to all persons including without limitation my physicians, health care providers and family. In the event my said **Son** predeceases me or is otherwise unable to serve as my health care proxy and attorney-in-fact under this appointment, then I nominate and appoint my **Husband, Larry Young** presently residing at **50 Saddle Ridge Drive Columbiana, AL 35051** to serve as substitute health care proxy and attorney-in-fact with all the powers and privileges **Dennis William Polley** would have had as my health care proxy and attorney-in-fact.

I specifically direct that my health care proxy and attorney-in-fact shall have the power and authority to make all health care decisions affecting me and my medical care and treatment including decisions with regards to my care that is consistent with my express wishes and instructions, in any "Living Will" that I have signed, or will hereafter sign, without limitation, to make decisions regarding the withholding or withdrawal of life-sustaining treatment and artificially provided nutrition and hydration in the event that I may be "terminally ill or injured" or suffering from "permanent unconsciousness" as these terms may be defined by §22-8A-3 of the Alabama Natural Death Act.

I further delegate to my health care proxy and attorney-in-fact the power and authority to select, employ and discharge health care personnel, such as physicians, nurses, therapists, home health care providers and other medical professionals, and to contract in my name and on my behalf for all health care services, including without limitation medical, nursing and hospital care, as my health care proxy and attorney-in-fact may deem appropriate. I confirm that I shall be and remain personally liable for the payment of all such care and services to the same extent as if I had personally contracted therefor. I specifically direct that my attorney-in-fact shall have the power and authority to execute any and all documents that may be necessary and incidental to my care and treatment at nursing homes, assisted living facilities, or similar health care providers, and to make any decisions necessary regarding my care and treatment at such facility, including the right to restrict any visitor(s) that my said attorney-in-fact may choose.

I authorize my health care proxy and attorney-in-fact to donate all or any part of my body for transplantation, therapy, advancement of medical or dental science, research, or other medical, educational or scientific purpose, or to otherwise direct the disposition of my remains.

I further authorize my health care proxy and attorney-in-fact to request, receive and review any information regarding my physical or mental health, including without limitation medical and hospital records; to execute on my behalf any releases or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. I authorize my health care proxy and attorney-in-fact to execute on my behalf any documents necessary or desirable to implement the health care decisions that my health care proxy and attorney-in-fact is authorized to make pursuant to this document,

including without limitation all documents pertaining to a refusal to permit medical treatment or authorizing the leaving of medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider.

I understand that I may revoke this document at any time.

This document is a durable power of attorney and the authority of my health care proxy and attorney- in-fact shall not terminate if I become disabled, incompetent, or incapacitated.

In witness whereof, I have executed this instrument, as my free and voluntary act and deed, this 11th day of Dec, 2020.

Jeannie Y. Young

Witness:

We, Deborah Williams and Rafael Cabello each hereby attest and declare under penalty of perjury under the laws of Alabama that: (1) the foregoing instrument was personally signed by Jeannie Yvonne Young in my presence, and thereupon I, at her request and in her presence and in the presence of the other witnesses, have hereunto subscribed my name as a witness: (2) I did not sign the above signature of Jeannie Yvonne Young, for or a her direction; (3) I personally know Jeannie Yvonne Young, and believe her to be of sound min and under no constraint, duress, fraud or undue influence; (4) I am not related to Jeannie Yvonne Young, by blood, marriage or adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of the estate of Jeannie Yvonne Young upon her death under any will or codicil of or by operation of law; (6) I do not6 have an present or inchoate claim against any portion of the estate of Jeannie Yvonne Young; (7) I do not have any financial responsibility for the medical care of Jeannie Yvonne Young; (8) I am not a physician or an employee of any physician, and I am not an operator or employee of, or patient in, any hospital, health care provider, residential care facility, community care facility or similar institution; (9) I am not a person named as health care proxy in this instrument; and (10) I and Rafael Cabello are both at least 18 years of age.

Dated: This 11th day of December, 2020.

Witness:

Address: 113 Pebble Drive

Alabaster, AL. 35007

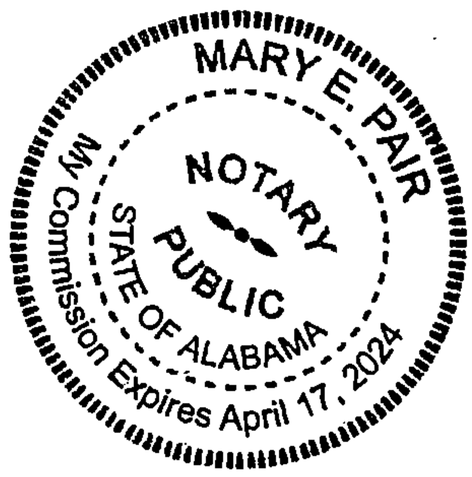
Witness:

Address: 8695 Cotton Road 4000 Greystone Drive Birmingham, AL 35242

STATE OF ALABAMA, COUNTY OF SHELBY

I, the undersigned, a notary public, hereby certify that Jeannie Yvonne Young, whose name is signed to the foregoing instrument, and who is known to me, acknowledged before me on this day, that being informed of the contents of said instrument, she executed the same voluntarily on this 11th day of December, 2020.

Give under my hand and official seal this 11th day of December, 2020.



Mary E Pair

Notary Public

My commission expires on:
April 17, 2024

Telephone Number:
205-617-1170