

STATE OF ALABAMA)
COUNTY OF SHELBY)


20230118000014490 1/3 \$28.00
Shelby Cnty Judge of Probate, AL
01/18/2023 09:57:17 AM FILED/CERT

***DURABLE POWER OF ATTORNEY
for Health Care and Living Will***

KNOW ALL MEN BY THESE PRESENTS, THAT I, **MARGARET LAVINIA WALDROP**, presently residing in Shelby, Alabama, and being an adult of sound mind, do hereby revoke all prior living wills and make, constitute, appoint and authorize **AMY DAWN THEABOLT**, as MY TRUE AND LAWFUL Attorney-In-Fact (HEREINAFTER REFERRED TO AS "Attorney-In-Fact") to act jointly in my name, place and stead and on my behalf and for my use and benefit, to do, perform and execute all and every act that I may legally do, perform and execute through an Attorney-In-Fact FOR THE LIMITED PURPOSE OF MAKING HEALTH CARE DECISIONS for and on my behalf including the power to make and communicate any and all decisions about or relating to my receipt or refusal to accept medical treatment, hospitalization, possible surgical procedures, health care or personal care, or other medical treatments, in any situation in which, as the result of illness, disease, mental deterioration or injury, I am incapable of making or communicating such decisions for myself.

I further delegate to my 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 Attorneys 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 further authorize my Attorney-In-Fact to request, receive and review any information regarding my physical and 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 Attorney-In-Fact to execute on my behalf any documents necessary or desirable to implement the health care decisions that my 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 a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider.

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized, and where the application of life-sustaining procedures would serve only to artificially prolong the dying process; or, in the event that there is no hope of my recovery, as evidenced by a written medical opinion, my Attorney-In-Fact shall be authorized to express my 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 to my physicians, health care providers and family. Upon the occurrence of the circumstances of my health as set forth in this Paragraph, I direct that my said Attorney-In-Fact shall assure that life-sustaining procedures be withheld and withdrawn, including artificial means of nutrition and hydration, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or

to alleviate pain. The procedures and treatment to be withheld and withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered feeding and fluids.

Upon the happening of the above circumstances, and in the absence of my ability to give directions regarding making of such health care decisions or the use of such life-sustaining procedures, it is my intention that this Durable Power of Attorney For Health Care And Living Will shall then be in full force and effect, and it is my further intention that the declarations contained herein shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and accept the consequences of such refusal.

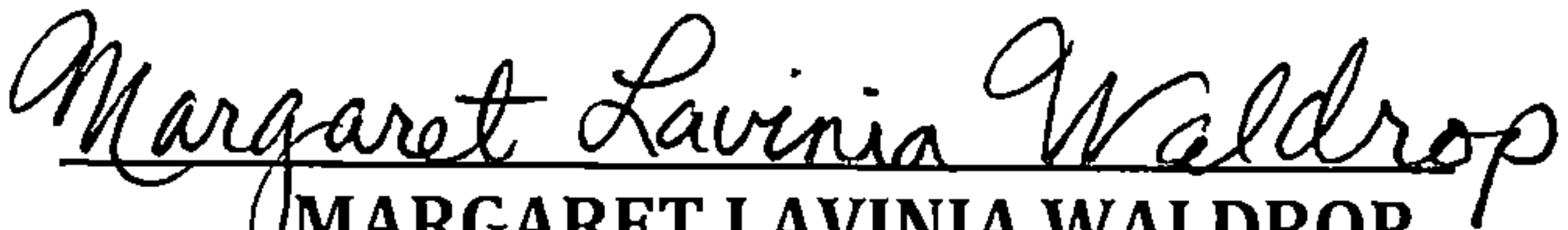
I understand the full import of this declaration, and I am aware that this declaration authorizes a physician to withhold and withdraw life-sustaining procedures. I am at least nineteen years of age and I am emotionally and mentally competent to make this declaration.

And I do hereby give and grant to my aforementioned Attorney-In-Fact hereunder, every proper power necessary to assure that the purposes for which this Durable Power of Attorney For Health Care And Living Will is granted are carried out, hereby ratifying and confirming each and every act which my said Attorneys in fact shall do by virtue of the power herein conferred on same.

In the event of the death, resignation, or inability to serve of **AMY DAWN THEABOLT**, I appoint **JEFFREY ALAN WALDROP**, to act as my successor Attorney-In-Fact in my name, place and stead with all rights, powers and authority as herein granted to my original Attorneys in fact.

This document shall be considered a durable power of attorney and shall take effect on the 18th day of January, 2023 and continue in existence during any period in which I am incapacitated or unable to act for myself, as shall be evidenced by a written statement by my Attorney-In-Fact.

IN WITNESS WHEREOF, I have executed, as principal, this Durable Power of Attorney For Health Care And Living Will, as my free and voluntary act and deed, this 18th day of January, 2023.


MARGARET LAVINIA WALDROP


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WITNESSES:

1) The foregoing instrument was personally signed by the Declarant in my presence, and thereupon I, at the Declarant's request and in the presence of the Declarant and in the presence of the other witnesses, have hereunto subscribed my name as a witness; (2) I did not sign the Declarant's signature above for or at the direction of the Declarant; (3) The Declarant has been personally known to me and I believe the Declarant to be of sound mind and under no constraint, duress, fraud or undue influence; (4) I am not related to the Declarant 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 the Declarant according to the laws of interstate succession or under any will or codicil of the Declarant; (6) I do not have any present inchoate claim against any portion of the estate of the Declarant; (7) I do not have any financial responsibility for the medical care of the Declarant; (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 in which the Declarant is a patient; (9) I am not a person named as Attorney-In-Fact in this instrument; and (10) I and the Declarant are both at least 19 years of age.

Dated the 18th day of January, 2023.

WITNESS:

Tina Bray

Signature of Witness

Tina Bray

Printed Name of Witness

Address: Po Box 537 Columbiana, AL 35051

Jeremy Waldrop

Signature of Witness

Jeremy Waldrop

Printed Name of Witness

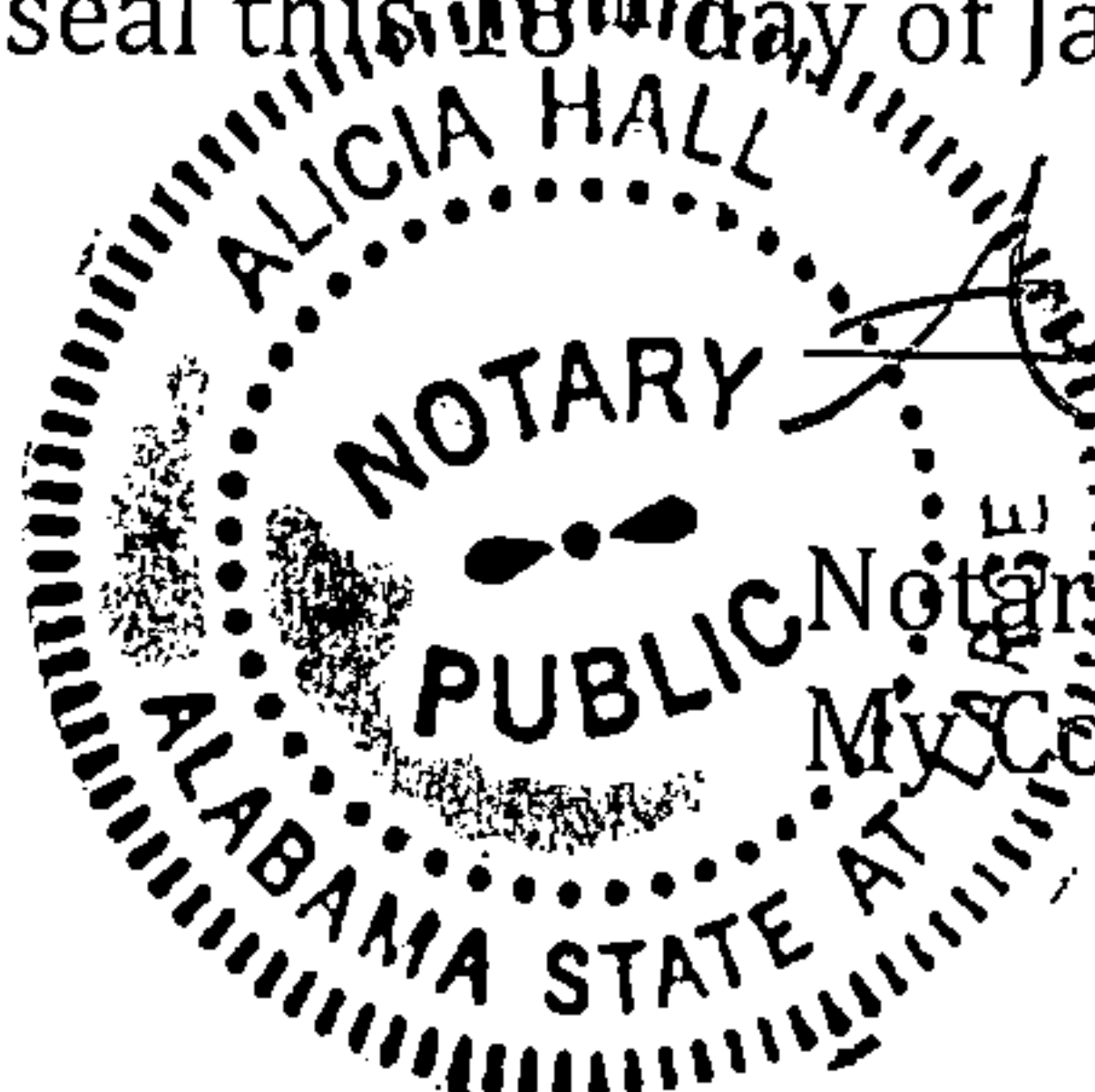
Address: 307 E Sterret St Columbiana, AL 35051

ACKNOWLEDGMENT

STATE OF ALABAMA)
COUNTY OF SHELBY)

I, the undersigned, a notary public, hereby certify that **MARGARET LAVINIA WALDROP**, whose name is signed to the foregoing Durable Power Of Attorney For Health Care And Living Will, and who is known to me, acknowledged before me on this day that, being informed of the contents of said Durable Power of Attorney For Health Care And Living Will, he executed the same voluntarily on this 18th day of January, 2023.

Given under my hand and official seal this 18th day of January, 2023.



Alicia Hall

Notary Public: Alicia Hall

My Commission Expires: 5/24/2026