DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, SALLY J. FLOYD, residing in Alameda County, California, hereby appoint CAROLE LEITA, whose telephone number is 510.334.2118, my true and lawful attorney-in-fact, hereinafter, "my agent". If CAROLE LEITA is unable or ceases to act as my agent, I appoint CRISCO MCCULLOUGH, whose telephone number is 916.214.4361, as my agent. This power of attorney shall become effective only upon my incapacity, continue notwithstanding my incapacity, and cease when I am deemed to have regained my capacity.

I designate my agent to determine, with the concurrence of a medical doctor who has treated or examined me within seven days, that I have become incapacitated. I understand that the power of attorney shall not be effective until my agent declares under penalty of perjury that I am incapacitated. That declaration shall include a warranty that my agent has consulted with a medical doctor who has treated or examined me within seven days, and that that doctor agrees with my agent's decision. My agent may not be held liable for executing this declaration in good faith.

SPECIFIC INSTRUCTIONS TO MY AGENT

A. Control My Own Care

So long as I am competent, I intend to control my own medical care. I therefore wish to be informed of my condition and prognosis so long as I am able to comprehend them. I would consider myself incompetent if I were unable to understand my illness, unable to grasp the nature and effect of proposed treatment, or to know the risk in either accepting it or refusing it.

B. Treat with Dignity

If I should suffer a serious disease, injury or illness, I desire that those who love and care for me should be close to me whenever possible. I ask that those involved in my personal and medical care conduct themselves so that it is apparent that I am included in their respect and care for all humanity, trying to make me aware of that respect through any of my senses, regardless of my condition. I particularly ask that I not be isolated with silence when dying.

C. Home Care

If at all possible, I desire to die at home with appropriate medical, nursing, social, and emotional support and any necessary medical or other equipment needed to keep me comfortable. Alternatively, you may choose hospice care, or care in a facility you deem appropriate.

D. No Futile Treatment

I wish to live and enjoy life as long as possible, but I do not wish to receive futile medical treatment which I define as treatment that will only secure a precarious and burdensome prolongation of life. I would consider treatment futile when I had irrevocably

lost the ability to interact knowingly and effectively with others. In general, I would, if competent, reject treatments that imposed on me suffering or strain out of proportion with the benefits expected to be gained by the use of such treatment.

It is my desire that you consider relief from suffering, preservation or restoration of functioning, and the quality as well as extent of the life being preserved when you are making decisions concerning my life-sustaining care, treatment, services and procedures. What is "reasonable," what is "an aid to recovery," and what is "merely postponing the moment of my death" shall be determined by you after consulting with my attending physician(s).

I direct you to do any or all of the following, if necessary:

a. Terminate any of my physicians who refuse to honor my above wishes and retain another physician for me who will agree to honor my wishes.

b. Present my case and my medical situation to any Ethics Committee of any hospital for review, evaluation and recommendation.

c. Take any other action and pursue any other procedure that may result in carrying out my above wishes.

I very strongly desire that my wishes regarding withholding and/or withdrawing life sustaining treatment be carried out by you despite any contrary feelings, beliefs or opinions of members of my immediate family, other relatives, or friends.

I prefer to be kept as comfortable and pain-free as possible even if the medication or other therapy or procedure(s) calculated to relieve my pain may lead to my injury, addiction, or even hasten my death. Alternative forms of treatment, including though not limited to acupuncture, herbal remedies, massage, homeopathy, and/or biofeedback, are acceptable to me.

Overall, I authorize you to exercise on my behalf my rights of liberty and privacy to make decisions regarding my medical treatment and my right to be left alone even though the exercise of these rights might hasten my death or be against conventional medical advice. You may take appropriate legal action, if necessary in your judgment, to enforce my rights in this regard.

I realize that the situations described in this document are subject to various interpretations, and I am confident that you will exercise the judgment that I myself would exercise if competent. If you are unavailable, I nevertheless request that my instructions in this document be observed as much as possible.

YOUR GENERAL POWERS

You shall also have the following powers:

A. Employment of health care personnel. To employ such physicians, dentists, nurses, therapists, and other professionals or non-professionals, as you may deem necessary or appropriate for my physical or mental well-being; and to pay from my funds reasonable compensation for all services performed by such persons.

B. Gain access to medical and other personal information. To request, review, and receive any information, oral or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain this information.

C. Consent, or refuse consent, to medical care. To give or withhold consent to medical care, surgery or any other medical procedures or tests; to arrange for my hospitalization, convalescent care or home care; and to revoke, withdraw, modify or change such consent. I ask you to be guided in making such decisions by what I have told you about my personal preferences regarding such care. Based on those same preferences, you may also summon paramedics or other emergency medical personnel and seek emergency treatment for me, or choose not to do so, as you deem appropriate given my wishes and my medical status at the time of the decision. You are authorized, when dealing with hospitals and physicians, to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" as well as any necessary waivers of or releases from liability required by the hospitals or physicians to implement my wishes regarding medical treatment or non-treatment.

D. Refuse life prolonging procedure. To request that aggressive medical therapy not be instituted or be discontinued. You should try to discuss the specifics of any such decision with me if I am able to communicate in any manner. If I am unreachable by such communication, you should make the decision guided by any preferences which I may have previously expressed and the information given by the physicians treating me as to my medical diagnosis and prognosis. You may request and concur with the writing of a "no-code" (do not resuscitate) order. 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 do not want my life prolonged if I am in a persistent vegetative state, and am deemed likely to remain in such state by my medical care providers. I want you to consider the relief of suffering and the quality as well as the length of a possible extension of my life in making decisions concerning life-sustaining treatment.

E. Disconnect or Remove Medical Devices. To direct the disconnection, removal, or otherwise to disable any medical devices previously connected to or installed in my body. This specifically includes pacemakers or similar machines that keep my heart, or any other organ functioning.

F. Protect my right of privacy. To exercise my right of privacy to make decisions regarding my medical treatment and my right to be left alone even though the exercise of my right might hasten death or be against conventional medical advice. You may take appropriate legal action to enforce my rights in this regard.

G. Execute documents and etc. To sign, execute, deliver, acknowledge and make declarations in any document or documents that may be necessary, desirable, convenient or proper in order to exercise any of the powers described in this section; to enter into contracts; and to pay reasonable compensation or costs in the exercise of any such powers.

H. Direct disposal of my remains. To allow, or refuse to allow an autopsy performed on my remains when I die. To determine, in your sole discretion, and regardless of the wishes of any other person, the disposition of my body, including the decision to donate organs or body parts.

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HIPAA RELEASE AND AUTHORIZATION

I authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to the agent(s) named in this Medical Power of Attorney, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

This authority shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider. This authorization is effective immediately upon my signing this document, regardless of other triggering requirements.

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA) 42 USC 1320d and 45 CFR 160-164, and all other applicable state and federal law.

NOMINATION OF CONSERVATOR

If a conservator of the person is to be appointed for me, I nominate my agent or agents, in the order listed in the initial paragraph above, to serve as conservator of the person.

RELIANCE ON PHOTOCOPIES

Any person dealing with my agent shall have the right to rely on a photocopy of this Power of Attorney, certified by my agent as being genuine, as if it were the signed, original Power of Attorney.

IN WITNESS WHEREOF, I have hereunto signed my name on

9/23/13 ______________.

Sally J. Floyd ______________
SALLY J. FLOYD

ACKNOWLEDGMENT

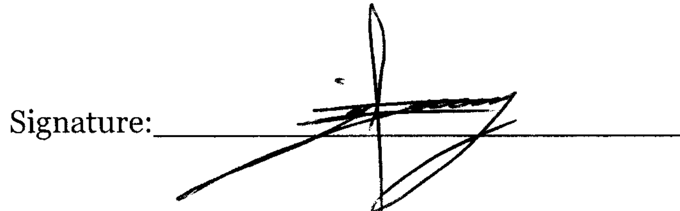
STATE OF CALIFORNIA)
)
COUNTY OF ALAMEDA)

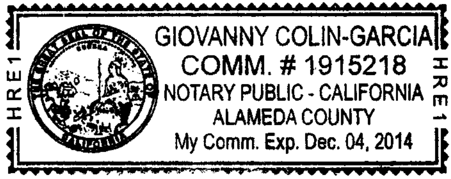
On September, 23, 2013, before me Giovanny Colin-Garcia, Notary Public, personally appeared SALLY J. FLOYD, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that she executed the same in her authorized capacity, and that by her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature:





DECLARATION THAT SALLY J. FLOYD IS INCAPACITATED

I declare under penalty of perjury under the laws of the State of California that the contingency specified in the Durable Power of Attorney dated _____________ and signed by SALLY J. FLOYD occurred on or about ____________________________.

Specifically, I declare that SALLY J. FLOYD is currently incapacitated. In making this decision, I have consulted with ______________________________, a medical doctor who has treated or examined SALLY J. FLOYD within the last seven days. Dr. ______________________________ concurs with my determination that SALLY J. FLOYD is currently incapacitated.

I declare under penalty of perjury that I am the person designated to act as Attorney in Fact under SALLY J. FLOYD's Medical Durable Power of Attorney. By executing this declaration I declare my intent to exercise my power under that Power of Attorney. Any person may act in reliance on this written declaration without liability to SALLY J. FLOYD or to any other person, regardless whether the specified contingency has actually occurred.

Date______________ ___________________________________
Attorney in Fact