ILLINOIS, MISSOURI, LOUISIANA

HEALTH CARE AND FINANCIAL DIRECTIVES

The following remarks regarding these documents are from our province attorney's office:

1) **Durable Power of Attorney for Financial Matters** –This form can be used in all States. Each Sister should insert her name, address, county and state of residence in the appropriate places. This document should be executed in the presence of "disinterested" witnesses and a notary public, who should complete the appropriate sections. The date of execution should also be completed.

2) **"Disinterested" Witness**-a witness who is eighteen (18) years of age, or over, and must be someone who is (i) not related to the Sister by blood or marriage, (ii) not named as an agent, (iii) not related to the named agent by blood or marriage, (iv) not entitled to receive any portion of the Sister's estate upon her death, (v) not a creditor or individual with a claim against the Sister's estate, and (vi) not a treating physician or employee of a treating physician or hospital.

3) **Medical Directive and Durable Power of Attorney for Health Care Decisions-**Each Sister should insert her name, address, and county and state of residence in the appropriate places. This document should be executed in the presence of two "disinterested" witnesses and a notary public who should complete the appropriate sections. The date of execution should be completed.

4) Our attorney recommends that each Sister communicate her wishes regarding medical treatment to whomever she selects to serve as her Agent, possibly by way of a letter. The legal documents are drafted broadly to give the appointed agent flexibility to handle any situation that may arise. Each Sister is encouraged to make her Agent informed and aware of her desires.

5) Before executing any document, each Sister should carefully review the document and remove any provision that is contrary to her intent.

Medical Directives and
Durable Power of Attorney
for Health Care Decisions
(MO, IL, LA)
[2 versions]

This document should be executed in the presence of two "disinterested" witnesses and a notary public, who should complete the appropriate sections. The date of execution should be completed.

A "disinterested" witness is a witness who is eighteen (18) years of age or over, and must be someone who is (i) not related to the Sister by blood or marriage, (ii) not named as an agent, (iii) not related to the named agent by blood or marriage, (iv) not entitled to receive any portion of the Sister's estate upon her death, (v) not a creditor or individual with a claim against the Sister's estate, and (vi) not a treating physician or employee of a treating physician or hospital.

[Missouri, Illinois, and Louisiana]

[Appoints Local Prioress]

MEDICAL DIRECTIVE

AND

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, _____, known in religion as

_____, OSU, a resident of the County

of _____, State of _____, declare this instrument to be my Medical

Directive and Durable Power of Attorney for Health Care Decisions.

1. Statement of Intent

I have the primary right to make my own decisions concerning my medical treatment, including the right to refuse any such medical treatment proposed to be administered to me. In the event that I am unable to exercise this right in the future because I am unable to participate in decisions regarding my medical treatment, I hereby voluntarily and willingly make this declaration, at a time when I am of sound mind and over 18 years of age, to express to my physician, my family and my friends my intentions regarding my medical treatment under the circumstances set forth below.

2. Medical Directive (Living Will Declaration)

If I should have an injury, disease or illness regarded by my attending physician as incurable and terminal so that my attending physician anticipates that I probably will not be alive in six months, I hereby direct that my dying not be prolonged by administration of artificial and/or heroic measures or procedures that would serve only to prolong the dying process. I direct my attending physician to follow the instructions of my Agent named hereafter concerning withholding or withdrawing any and all medical procedures, including artificial nutrition and hydration, that merely artificially prolong my life and to permit me to die naturally with only the merciful administration of medication to provide me with maximum comfort during my terminal suffering even if such medication would hasten the moment of death. If I am in an irreversible coma or in a persistent vegetative state and my attending physician does not expect me to recover consciousness, I further direct my attending physician to follow the instructions of my Agent named hereafter concerning withholding or withdrawing any and all medical or other procedures, including artificial nutrition and hydration, and to permit me to die naturally, quickly and peacefully.

3. Power of Attorney for Health Care Decisions

3.1. Appointment of Agent

In order to implement my intentions expressed herein, the person who is the local prioress of the local Ursuline community of which I am a member ("My Local Prioress) at the time the powers and duties granted hereunder shall commence under Article 3.5, and each person who shall thereafter serve as My Local Prioress, shall be my Agent to make health care decisions for me; each such person to act as my Agent for as long as she is My Local Prioress.

In responding to, following the instructions of, or otherwise dealing with any person acting as my Agent hereunder, third parties, without liability to me or my successors in interest, may rely upon a written statement of the Provincial Prioress of the Ursuline Provincialate, Central Province of the United States that such person acting as my Agent is My Local Prioress.

3.2. General Powers for Health Care Purposes Granted

I give and grant unto my said Agent for health care decisions full power and authority to make health care decisions for me and in my name, including but not limited to the power to consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, do and perform every act necessary and proper to be done in the exercise of any of the foregoing powers as fully as I might or could do if I were then personally able to participate in such health care decisions, and I hereby ratify and confirm all that my said Agent shall lawfully do or cause to be done by virtue hereof.

3.3. Expressly Authorized Actions

In addition to the general power and authority granted above, my Agent hereunder shall have the following expressly enumerated powers; provided, however, that nothing herein shall be deemed to restrict in any way the above general grant of authority:

3.3.1. Access to Health Care Records (HIPAA Release Authority)

To have the same access to my individually identifiable health information and health care records that I could have, including the right to disclose the contents to others and to discuss treatment decisions with health care personnel and others. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d and 45 CFR 160-164 (hereafter "HIPAA").

The authority given my Agent 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 in this Article 3.3.1 shall expire only in the event that I revoke such authority in writing and deliver it to my health-care provider.

For purposes of HIPAA, my Agent shall be treated as my "Personal Representative" (as that term is used under HIPAA).

3.3.2. Retain Health Care Providers

To retain and dismiss health care and social service providers, and other support personnel responsible for my care.

3.3.3. Adjust Health Care Institutions

To admit or transfer me to or discharge me from (even against medical advice) any health care institution, nursing home, assisted living facility, or other facility or program, within or outside of the state in which I reside.

3.3.4. Health Care Treatments

To consent to giving, withholding or ending any health care treatment, service or diagnostic procedure, including, but not limited to, cardiopulmonary resuscitation and the like, to give "no code" instructions, and to sign authorizations necessary to carry out these decisions.

3.3.5. Withhold Artificial Nutrition and Hydration

To direct a health care provider to withhold or withdraw artificial nutrition and hydration.

3.3.6. Gifts of Body Parts

To make or decline to make a gift of my body or a part thereof at my death under the Uniform Anatomical Gift Act.

3.3.7. Autopsy

To give or withhold consent to an autopsy or postmortem examination.

3.3.8. Appoint Guardians

To nominate one or more persons (including my said Agent hereunder) to serve as guardian of my person; in the event a guardian, other than my said Agent, is appointed by a court for me, however, I hereby direct that my said Agent appointed herein, and not such guardian, shall continue to make such health care decisions for me pursuant to this Durable Power of Attorney.

3.3.9. Delegate Decision Making Power and Other Actions

To delegate her health care decision making power to another person.

3.4. Reasonable and Necessary Powers

In addition to any other power granted herein, my Agent has the power and authority to take any legal action reasonably necessary to do what I have directed in this instrument.

3.5. Commencement of Authority

The powers and duties of my Agent for health care decisions shall commence if and when I become incapacitated, which shall occur, for purposes of this instrument, when I am unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions concerning my medical care. My incapacity shall be deemed to exist when two physicians, one of whom is my attending physician, certify in writing that in their opinion I am incapacitated. If two physicians, one of whom is my attending physician, subsequently certify in writing that I have regained my capacity, this Durable Power of Attorney for Health Care Decisions shall not be revoked but shall become effective again upon my subsequent incapacity as provided above. Notwithstanding the foregoing, the physicians who so certify my incapacity need not incorporate the certification into my records, set forth the facts upon which the determination of incapacity is based, set forth the expected duration of my incapacity, or periodically review their determination of incapacity unless requested to do so in any such case by my Agent designated herein.

Notwithstanding anything herein to the contrary, for the sole purpose of determining whether I am incapacitated (i.e. whether my Agent's powers and duties have commenced), my Agent's authority to access my individually identifiable health information and health care records (including any written opinion relating to whether I am incapacitated) pursuant to Article 3.3.1, shall commence immediately upon execution of this instrument.

3.6. Duty to Seek Information

In making any decision hereunder, including but not limited to the decision to withdraw treatment, my Agent for health care decisions shall seek and consider information concerning my medical diagnosis, my prognosis and the benefits and burdens of the treatment to me to the extent possible within prevailing medical standards.

3.7. Reimbursement of Expenses

As I do not wish to financially burden my Agent for health care decisions for services hereunder, my Agent shall be entitled to reimbursement, out of my assets or out of any trust created by me for my benefit, for the reasonable expenses incurred as a result of acting as my Agent hereunder.

3.8. Revocation of Prior Powers of Attorney for Health Care Decisions

This Durable Power of Attorney for Health Care Decisions revokes any prior power of attorney for health care other than my most recent DURABLE POWER OF ATTORNEY FOR FINANCIAL MATTERS, which I have executed before, or contemporaneously with, the execution of this Durable Power of Attorney, and under which I have authorized the agent appointed under that instrument to arrange for medical and health care on my behalf.

4. General Directives

The directives contained herein are general and have been made after careful consideration. I recognize that I cannot presently foresee all possible situations and evaluate what my response to those situations would be. Therefore, I have granted my Agent for health care decisions broad power and authority to make decisions in response to specific situations regarding my health care. I trust the person(s) who may act as my Agent and successor Agent hereunder. I direct my health care providers to look to my Agent for health care decisions when making specific decisions regarding my health care. I realize and intend that such decisions shall include the power to refuse, or withdraw, consent to medical treatment designed to keep me alive.

5. Revocability of this Instrument

This Medical Directive and Durable Power of Attorney for Health Care Decisions may be revoked by me at any time and in any manner, which revocation shall be effective upon my communication of such revocation to my Agent for health care decisions, or to my attending physician or health care provider. No physician, nurse, hospital or other health care provider who, without actual knowledge that I have countermanded such instructions, in reliance upon this instrument or upon the instructions of my Agent, (i) administers, withholds or withdraws any medical treatment, life-sustaining treatment or death-prolonging procedures or (ii) performs any medical treatment shall have any liability or responsibility to me, my estate or any other person for having withheld, withdrawn or performed such treatment or procedure in good faith. Anything to the contrary herein notwithstanding, the authority of my Agent shall continue after knowledge of my death has been received for the limited purpose of carrying out the authority granted in Sections 3.3.6 and 3.3.7 of this instrument.

THIS IS A DURABLE POWER OF ATTORNEY TO MAKE HEALTH CARE DECISIONS AND THE AUTHORITY OF MY AGENT. IT SHALL BECOME EFFECTIVE IF AND WHEN, AND SHALL NOT TERMINATE IF I AM UNABLE TO PARTICIPATE IN DECISIONS REGARDING MY MEDICAL TREATMENT.

I have executed multiple original copies of this instrument on this _____ day of

_____, 20_____.

_____

_____, known in

religion as _____, OSU

We certify that _____, known in religion as _____, OSU, is personally known to us, is 18 years of age or older, is of sound mind, and voluntarily signed this instrument in our presence. We are not named as an Agent or successor Agent in this instrument.

WITNESSES:	ADDRESSES:
_____	_____
	_____
_____	_____
	_____

STATE OF _____)
) ss.
COUNTY OF _____)

On this _____ day of _____, 20____, personally appeared before me _____, known in religion as _____, OSU, to me known to be the person described in and who executed the foregoing instrument and acknowledged that she executed the same as her free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal on the day and year first above written.

_____
Notary Public

641638 v2

[Missouri, Illinois, and Louisiana]

[Appoints someone other than Local Prioress]

MEDICAL DIRECTIVE

AND

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, _____, known in religion as

_____, OSU, a resident of the County

of _____, State of _____, declare this instrument to be my Medical

Directive and Durable Power of Attorney for Health Care Decisions.

6. Statement of Intent

I have the primary right to make my own decisions concerning my medical treatment, including the right to refuse any such medical treatment proposed to be administered to me. In the event that I am unable to exercise this right in the future because I am unable to participate in decisions regarding my medical treatment, I hereby voluntarily and willingly make this declaration, at a time when I am of sound mind and over 18 years of age, to express to my physician, my family and my friends my intentions regarding my medical treatment under the circumstances set forth below.

7. Medical Directive (Living Will Declaration)

If I should have an injury, disease or illness regarded by my attending physician as incurable and terminal so that my attending physician anticipates that I probably will not be alive in six months, I hereby direct that my dying not be prolonged by administration of artificial and/or heroic measures or procedures that would serve only to prolong the dying process. I direct my attending physician to follow the instructions of my Agent named hereafter concerning withholding or withdrawing any and all medical procedures, including artificial nutrition and hydration, that merely artificially prolong my life and to permit me to die naturally with only the merciful administration of medication to provide me with maximum comfort during my terminal suffering even if such medication would hasten the moment of death. If I am in an irreversible coma or in a persistent vegetative state and my attending physician does not expect me to recover consciousness, I further direct my attending physician to follow the instructions of my Agent named hereafter concerning withholding or withdrawing any and all medical or other procedures, including artificial nutrition and hydration, and to permit me to die naturally, quickly and peacefully.

8. Power of Attorney for Health Care Decisions

8.1. Appointment of Agent

In order to implement my intentions expressed herein, I appoint _____ as my Agent to make health care decisions for me. In the event that my Agent named above shall resign, die or become incapable of acting as my Agent hereunder, then I appoint _____ to act as my Agent thereafter. In the event that _____ shall resign, die or become incapable of acting as my Agent hereunder, then I appoint _____ to act as my Agent thereafter.

8.2. General Powers for Health Care Purposes Granted

I give and grant unto my said Agent for health care decisions full power and authority to make health care decisions for me and in my name, including but not limited to the power to consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, do and perform every act necessary and proper to be done in the exercise of any of the foregoing powers as fully as I might or could do if I were then personally able to participate in such health care decisions, and I hereby ratify and confirm all that my said Agent shall lawfully do or cause to be done by virtue hereof.

I request, but do not direct, that my said Agent consult with the person who holds the office of Provincial Prioress of the Ursuline Provincialate, Central Province of the United States with respect to major issues concerning my health care, before making decisions concerning such issues, if it is feasable to do so. I will rely on my said Agent to determine what is and is not a major issue concerning my health care. I suggest, however, that such issues would include the authorization of extremely expensive or elective medical procedures.

8.3. Expressly Authorized Actions

In addition to the general power and authority granted above, my Agent hereunder shall have the following expressly enumerated powers; provided, however, that nothing herein shall be deemed to restrict in any way the above general grant of authority:

8.3.1. Access to Health Care Records (HIPAA Release Authority)

To have the same access to my individually identifiable health information and health care records that I could have, including the right to disclose the contents to others and to discuss treatment decisions with health care personnel and others. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d and 45 CFR 160-164 (hereafter "HIPAA").

The authority given my Agent 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 in this Article 3.3.1 shall expire only in the event that I revoke such authority in writing and deliver it to my health-care provider. For purposes of HIPAA, my Agent shall be treated as my "Personal Representative" (as that term is used under HIPAA).

8.3.2. Retain Health Care Providers

To retain and dismiss health care and social service providers, and other support personnel responsible for my care.

8.3.3. Adjust Health Care Institutions

To admit or transfer me to or discharge me from (even against medical advice) any health care institution, nursing home, assisted living facility, or other facility or program, within or outside of the state in which I reside.

8.3.4. Health Care Treatments

To consent to giving, withholding or ending any health care treatment, service or diagnostic procedure, including, but not limited to, cardiopulmonary resuscitation and the like, to give "no code" instructions, and to sign authorizations necessary to carry out these decisions.

8.3.5. Withhold Artificial Nutrition and Hydration

To direct a health care provider to withhold or withdraw artificial nutrition and hydration.

8.3.6. Gifts of Body Parts

To make or decline to make a gift of my body or a part thereof at my death under the Uniform Anatomical Gift Act.

8.3.7. Autopsy

To give or withhold consent to an autopsy or postmortem examination.

8.3.8. Appoint Guardians

To nominate one or more persons (including my said Agent hereunder) to serve as guardian of my person; in the event a guardian, other than my said Agent, is appointed by a court for me, however, I hereby direct that my said Agent appointed herein, and not such guardian, shall continue to make such health care decisions for me pursuant to this Durable Power of Attorney.

8.3.9. Delegate Decision Making Power and Other Actions

To delegate his or her health care decision making power to another person.

8.4. Reasonable and Necessary Powers

In addition to any other power granted herein, my Agent has the power and authority to take any legal action reasonably necessary to do what I have directed in this instrument.

8.5. Commencement of Authority

The powers and duties of my Agent for health care decisions shall commence if and when I become incapacitated, which shall occur, for purposes of this instrument, when I am unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions concerning my medical care. My incapacity shall be deemed to exist when two physicians, one of whom is my attending physician, certify in writing that in their opinion I am incapacitated. If two physicians, one of whom is my attending physician, subsequently certify in writing that I have regained my capacity, this Durable Power of Attorney for Health Care Decisions shall not be revoked but shall become effective again upon my subsequent incapacity as provided above. Notwithstanding the foregoing, the physicians who so certify my incapacity need not incorporate the certification into my records, set forth the facts upon which the determination of incapacity is based, set forth the expected duration of my incapacity, or periodically review their determination of incapacity unless requested to do so in any such case by my Agent designated herein.

Notwithstanding anything herein to the contrary, for the sole purpose of determining whether I am incapacitated (i.e. whether my Agent's powers and duties have commenced), my Agent's authority to access my individually identifiable health information and health care records (including any written opinion relating to whether I am incapacitated) pursuant to Article 3.3.1, shall commence immediately upon execution of this instrument.

8.6. Duty to Seek Information

In making any decision hereunder, including but not limited to the decision to withdraw treatment, my Agent for health care decisions shall seek and consider information concerning my medical diagnosis, my prognosis and the benefits and burdens of the treatment to me to the extent possible within prevailing medical standards.

8.7. Reimbursement of Expenses

As I do not wish to financially burden my Agent for health care decisions for services hereunder, my Agent shall be entitled to reimbursement, out of my assets or out of any trust created by me for my benefit, for the reasonable expenses incurred as a result of acting as my Agent hereunder.

8.8. Revocation of Prior Powers of Attorney for Health Care Decisions

This Durable Power of Attorney for Health Care Decisions revokes any prior power of attorney for health care other than my most recent DURABLE POWER OF ATTORNEY FOR FINANCIAL MATTERS, which I have executed before, or contemporaneously with, the execution of this Durable Power of Attorney, and

under which I have authorized the agent appointed under that instrument to arrange for medical and health care on my behalf.

9. General Directives

The directives contained herein are general and have been made after careful consideration. I recognize that I cannot presently foresee all possible situations and evaluate what my response to those situations would be. Therefore, I have granted my Agent for health care decisions broad power and authority to make decisions in response to specific situations regarding my health care. I trust the person(s) who may act as my Agent and successor Agent hereunder. My Agent is familiar with my wishes and beliefs, and I direct my health care providers to look to my Agent for health care decisions when making specific decisions regarding my health care. I realize and intend that such decisions shall include the power to refuse, or withdraw, consent to medical treatment designed to keep me alive.

10. Revocability of this Instrument

This Medical Directive and Durable Power of Attorney for Health Care Decisions may be revoked by me at any time and in any manner, which revocation shall be effective upon my communication of such revocation to my Agent for health care decisions, or to my attending physician or health care provider. No physician, nurse, hospital or other health care provider who, without actual knowledge that I have countermanded such instructions, in reliance upon this instrument or upon the instructions of my Agent, (i) administers, withholds or withdraws any medical treatment, life-sustaining treatment or death-prolonging procedures or (ii) performs any medical treatment shall have any liability or responsibility to me, my estate or any other person for having withheld, withdrawn or performed such treatment or procedure in good faith. Anything to the contrary herein notwithstanding, the authority of my Agent shall continue after knowledge of my death has been received for the limited purpose of carrying out the authority granted in Sections 3.3.6 and 3.3.7 of this instrument.

THIS IS A DURABLE POWER OF ATTORNEY TO MAKE HEALTH CARE DECISIONS AND THE AUTHORITY OF MY AGENT. IT SHALL BECOME EFFECTIVE IF AND WHEN, AND SHALL NOT TERMINATE IF I AM UNABLE TO PARTICIPATE IN DECISIONS REGARDING MY MEDICAL TREATMENT.

I have executed multiple original copies of this instrument on this _____ day of _____, 20_____.

_____

_____, known in religion as _____, OSU

We certify that _____, known in religion as _____, OSU, is personally known to us, is 18 years of age or older, is of sound mind, and voluntarily signed this instrument in our presence. We are not named as an Agent or successor Agent in this instrument.

WITNESSES:	ADDRESSES:
_____	_____
	_____
_____	_____
	_____

STATE OF _____)
) ss.
COUNTY OF _____)

On this _____ day of _____, 20____, personally appeared before me _____, known in religion as _____, OSU, to me known to be the person described in and who executed the foregoing instrument and acknowledged that she executed the same as her free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal on the day and year first above written.

_____
Notary Public

720067v1

MINNESOTA

HEALTH CARE AND FINANCIAL DIRECTIVES

The following remarks regarding these documents are from our province attorney's office:

6) **Durable Power of Attorney for Financial Matters** –This form can be used in all States. Each Sister should insert her name, address, county and state of residence in the appropriate places. This document should be executed in the presence of "disinterested" witnesses and a notary public, who should complete the appropriate sections. The date of execution should also be completed.

7) **"Disinterested" Witness**-a witness who is eighteen (18) years of age, or over, and must be someone who is (i) not related to the Sister by blood or marriage, (ii) not named as an agent, (iii) not related to the named agent by blood or marriage, (iv) not entitled to receive any portion of the Sister's estate upon her death, (v) not a creditor or individual with a claim against the Sister's estate, and (vi) not a treating physician or employee of a treating physician or hospital.

8) **Health Care Living Will**- This form is prepared in accordance with Minnesota's law. Each Sister should insert her name and birth date in the appropriate places. She should also complete each of the Sections (1) through (7), and Section (9). The Sister should sign and date this document either in the presence of two "disinterested" witness OR a notary public, with the appropriate section completed by either the witnesses or notary public. Note: There are two copies of this form. One appoints the Local Prioress as the agent, one has space to name someone else other than the local prioress.

9) Our attorney recommends that each Sister communicate her wishes regarding medical treatment to whomever she selects to serve as her Agent, possibly by way of a letter. The legal documents are drafted broadly to give the appointed agent flexibility to handle any situation that may arise. Each Sister is encouraged to make her Agent informed and aware of her desires.

10) Before executing any document, each Sister should carefully review the document and remove any provision that is contrary to her intent.

Health Care Living Will
(Minnesota)
[2 versions]

Each Sister should insert her name and birth in the appropriate places. She should also complete each of the sections (1) through (7) and section (9). The Sister should sign and date this document either in the presence of two "disinterested" witnesses OR a notary public, with the appropriate section completed by the witnesses or notary public.

A "disinterested" witness is a witness who is eighteen (18) years of age or over, and must be someone who is (i) not related to the Sister by blood or marriage, (ii) not named as an agent, (iii) not related to the named agent by blood or marriage, (iv) not entitled to receive any portion of the Sister's estate upon her death, (v) not a creditor or individual with a claim against the Sister's estate, and (vi) not a treating physician or employee of a treating physician or hospital.

[Minnesota]
[Appoints Local Prioress]

HEALTH CARE LIVING WILL

Notice:

This is an important legal document. Before signing this document, you should know these important facts:

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy, that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the living will at any time by notifying your health care providers.

(d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

TO MY FAMILY, DOCTORS AND ALL THOSE CONCERNED WITH MY CARE:

I, _____, known in religion as

_____, OSU, born on _____ (birthdate), being

an adult of sound mind, willfully and voluntarily make this statement as a directive to be followed

if I am in a terminal condition and become unable to participate in decisions regarding my health care. I understand that my health care providers are legally bound to act consistently with my wishes, within the limits of reasonable medical practice and other applicable law. I also understand that I have the right to make medical and health care decisions for myself as long as I am able to do so and to revoke this living will at any time.

(1) The following are my feelings and wishes regarding my health care (you may state the circumstances under which this living will applies):

_____

_____

(2) I particularly want to have all appropriate health care that will help in the following ways (you may give instructions for care you do want):

_____

_____

(3) I particularly do not want the following (you may list specific treatment you do not want in certain circumstances):

_____

_____

(4) I particularly want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do want if you have a terminal condition):

_____

_____

(5) I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition):

_____

_____

(6) I recognize that if I reject artificially administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially administered sustenance should I have a terminal condition (you may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition):

_____

_____

(7) Thoughts I feel are relevant to my instructions. (You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care.)

_____

_____

(8) Proxy Designation. (If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.

If I become unable to communicate my instructions, I designate the person who is the local prioress of the local Ursuline community of which I am a member ("My Local Prioress") at the time this living will shall take effect hereunder, and each person who shall thereafter serve as My Local Prioress, to act on my behalf consistently with my instructions, if any, as stated in this document; each such person to act as my proxy for as long as she is My Local Prioress. In responding to, following the instructions of, or otherwise dealing with any person acting as my proxy hereunder, third parties, without liability to me or my successors in interest, may rely upon a written statement of the Provincial Prioress of the Ursuline Provincialate, Central Province of the United States that such person acting as my proxy is My Local Prioress. Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian or conservator of the person is to be appointed for me, I nominate my proxy in this document to act as guardian or conservator of my person.

I understand that I have the right to revoke the appointment of the person named above to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

(9) Organ Donation after Death. (If you wish, you may indicate whether you want to be an organ donor upon your death.) Initial the statement which expresses your wish:

____ In the event of my death, I would like to donate my organs. I understand that to become an organ donor, I must be declared brain dead. My organ function may be maintained artificially on a breathing machine (i.e., artificial ventilation), so that my organs can be removed.

Limitations or special wishes (if any): _____

_____

I understand that, upon my death, my next of kin may be asked permission for donation. Therefore, it is in my best interests to inform my next of kin about my decision ahead of time and ask them to honor my request.

I (have) (have not) agreed in another document or on another form to donate some or all of my organs when I die.

____ I do not wish to become an organ donor upon my death.

Date: _____ Signed: _____

STATE OF _____)
) ss.
COUNTY OF _____)

Subscribed, sworn to, and acknowledged before me by _____,

on this _____ day of _____, 200_____.

_____
Notary Public

OR

(Sign and date here in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a Will or by operation of law, and neither of whom is your proxy.)

I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will, and to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a Will or by operation of law.

WITNESSES	ADDRESSES
_____	_____
_____	_____

Reminder: Keep this signed original with your personal papers.
Give signed copies to your doctors, family and proxy.

635217 v2

[Minnesota]

[Appoints Someone other than Local Prioress]

HEALTH CARE LIVING WILL

Notice:

This is an important legal document. Before signing this document, you should know these important facts:

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy, that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the living will at any time by notifying your health care providers.

(d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

TO MY FAMILY, DOCTORS AND ALL THOSE CONCERNED WITH MY CARE:

I, _____, known in religion as

_____, OSU, born on _____ (birthdate), being an adult of

sound mind, willfully and voluntarily make this statement as a directive to be followed if I am in a

terminal condition and become unable to participate in decisions regarding my health care. I

understand that my health care providers are legally bound to act consistently with my wishes,

within the limits of reasonable medical practice and other applicable law. I also understand that

I have the right to make medical and health care decisions for myself as long as I am able to do

so and to revoke this living will at any time.

(1) The following are my feelings and wishes regarding my health care (you may state the circumstances under which this living will applies):

_____

_____

(2) I particularly want to have all appropriate health care that will help in the following ways (you may give instructions for care you do want):

_____

_____

(3) I particularly do not want the following (you may list specific treatment you do not want in certain circumstances):

_____

_____

(4) I particularly want to have the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do want if you have a terminal condition):

_____

_____

(5) I particularly do not want the following kinds of life-sustaining treatment if I am diagnosed to have a terminal condition (you may list the specific types of life-sustaining treatment that you do not want if you have a terminal condition):

_____

_____

(6) I recognize that if I reject artificially administered sustenance, then I may die of dehydration or malnutrition rather than from my illness or injury. The following are my feelings and wishes regarding artificially administered sustenance should I have a terminal condition (you may indicate whether you wish to receive food and fluids given to you in some other way than by mouth if you have a terminal condition):

_____

_____

(7) Thoughts I feel are relevant to my instructions. (You may, but need not, give your religious beliefs, philosophy, or other personal values that you feel are important. You may also state preferences concerning the location of your care.)

_____

_____

(8) Proxy Designation. (If you wish, you may name someone to see that your wishes are carried out, but you do not have to do this. You may also name a proxy without including specific instructions regarding your care. If you name a proxy, you should discuss your wishes with that person.

If I become unable to communicate my instructions, I designate the following person(s) to act on my behalf consistently with my instructions, if any, as stated in this document. Unless I write instructions that limit my proxy's authority, my proxy has full power and authority to make health care decisions for me. If a guardian or conservator of the person is to be appointed for me, I nominate my proxy in this document to act as guardian or conservator of my person.

Name: _____
Address: _____
Phone Number: _____
Relationship (if any):_____

If the person I have named above refuses or is unable or unavailable to act on my behalf, or if I revoke that person's authority to act as my proxy, I authorize the following person(s) to do so, who shall serve successively in the following order:

Name: _____
Address: _____
Phone Number: _____
Relationship (if any):_____

Name: _____
Address: _____
Phone Number: _____
Relationship (if any):_____

I understand that I have the right to revoke the appointment of the person named above to act on my behalf at any time by communicating that decision to the proxy or my health care provider.

(9) Organ Donation after Death. (If you wish, you may indicate whether you want to be an organ donor upon your death.) Initial the statement which expresses your wish:

____ In the event of my death, I would like to donate my organs. I understand that to become an organ donor, I must be declared brain dead. My organ function may be maintained artificially on a breathing machine (i.e., artificial ventilation), so that my organs can be removed.

Limitations or special wishes (if any): _____
_____

I understand that, upon my death, my next of kin may be asked permission for donation. Therefore, it is in my best interests to inform my next of kin about my decision ahead of time and ask them to honor my request.

I (have) (have not) agreed in another document or on another form to donate some or all of my organs when I die.

____ I do not wish to become an organ donor upon my death.

Date: _____ Signed: _____

STATE OF _____)
) ss.
COUNTY OF _____)

Subscribed, sworn to, and acknowledged before me by _____, on this _____ day of _____, 20_____.

_____
Notary Public

OR

(Sign and date here in the presence of two adult witnesses, neither of whom is entitled to any part of your estate under a Will or by operation of law, and neither of whom is your proxy.)

I certify that the declarant voluntarily signed this living will in my presence and that the declarant is personally known to me. I am not named as a proxy by the living will, and to the best of my knowledge, I am not entitled to any part of the estate of the declarant under a Will or by operation of law.

WITNESSES ADDRESSES

_____ _____

_____ _____

Reminder: Keep this signed original with your personal papers.
Give signed copies to your doctors, family and proxy.

721467v1

TEXAS

HEALTH CARE AND FINANCIAL DIRECTIVES

The following remarks regarding these documents are from our province attorney's office:

11) **Durable Power of Attorney for Financial Matters** –This form can be used in all States. Each Sister should insert her name, address, county and state of residence in the appropriate places. This document should be executed in the presence of "disinterested" witnesses and a notary public, who should complete the appropriate sections. The date of execution should also be completed.

12) **"Disinterested" Witness**-a witness who is eighteen (18) years of age, or over, and must be someone who is (i) not related to the Sister by blood or marriage, (ii) not named as an agent, (iii) not related to the named agent by blood or marriage, (iv) not entitled to receive any portion of the Sister's estate upon her death, (v) not a creditor or individual with a claim against the Sister's estate, and (vi) not a treating physician or employee of a treating physician or hospital.

13) **Medical Power of Attorney; Designation of Health Care Agent** – Attached to this document is a document entitled "Information concerning the Medical Power of Attorney." These forms are prepared in accordance with Texas statutes. Each Sister should insert her name as well as the locations where the originals of the document will be kept. The Sister should sign and date this document in the presence of two "disinterested" witnesses, who should complete the appropriate section. The location where the document is executed should be inserted. There are two versions of this document. One appoints the local prioress as the agent. The other appoints someone else.

14) **Directive to Physicians and Family or Surrogates**. This form is the preferred Living Will form for a Texas resident. It is an additional document to be used in Texas, since the statutory Medical Power of Attorney does not include the provisions commonly found in a Living Will.

15) Our attorney recommends that each Sister communicate her wishes regarding medical treatment to whomever she selects to serve as her Agent, possibly by way of a letter. The legal documents are drafted broadly to give the appointed agent flexibility to handle any situation that may arise. Each Sister is encouraged to make her Agent informed and aware of her desires.

16) Before executing any document, each Sister should carefully review the document and remove any provision that is contrary to her intent.

Medical Power of Attorney:
Designation of Health Care Agent
(Texas)
[2 versions]

Each Sister should insert her name as well as the location where the originals of the document will be kept. The Sisters should sign and date this document in the presence of two "disinterested" witnesses, who should complete the appropriate section. The location where the document is executed should be inserted (applies to section 5 also).

A "disinterested" witness is a witness who is eighteen (18) years of age or over, and must be someone who is (i) not related to the Sister by blood or marriage, (ii) not named as an agent, (iii) not related to the named agent by blood or marriage, (iv) not entitled to receive any portion of the Sister's estate upon her death, (v) not a creditor or individual with a claim against the Sister's estate, and (vi) not a treating physician or employee of a treating physician or hospital.

[Texas]

[Appoints Local Prioress]

MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

I, _____ known in

religion as _____, OSU

appoint the person who is the local prioress of the local Ursuline community of which I am a member ("My Local Prioress") at the time this medical power of attorney shall take effect hereunder, and each person who shall thereafter serve as My Local Prioress, as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document; each such person to act as my agent for as long as she is My Local Prioress. In responding to, following the instructions of, or otherwise dealing with any person acting as my agent hereunder, third parties, without liability to me or my successors in interest, may rely upon a written statement of the Provincial Prioress of the Ursuline Provincialate, Central Province of the United States that such person acting as my agent is My Local Prioress. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified, in writing, by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent, but you may do so. An alternate agent may make the same health care decisions as the designated agent, if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law, if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order: each person who succeeds to the office of My Local Prioress.

The original of this document is kept at:

_____

_____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

DURATION.

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

(IF APPLICABLE) This power of attorney ends on the following date: Not applicable.

PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this medical power of attorney on _____ day of _____, 20___ at

_____ (City, State).

_____

_____
(Print Name)

STATEMENT OF FIRST WITNESS

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____ Print Name: _____

Date: _____ Address: _____

_____

SIGNATURE OF SECOND WITNESS

Signature: _____ Print Name: _____

Date: _____ Address: _____

_____

635348 v2

INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY
[Disclosure Statement]

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over

your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;

(2) a person related to you by blood or marriage;

(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;

(4) your attending physician;

(5) an employee of your attending physician;

(6) an employee of a health care facility in which you are a patient, if the employee is providing direct patient care to you or is an officer, director, partner or business office employee of the health care facility or of any parent organization of the health care facility; or

(7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

635348v2

[Texas]

[Appoints someone other than the Local Prioress]

MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

I, _____ appoint

_____ as my agent to

make any and all health care decisions for me, except to the extent I state otherwise in this

document. This medical power of attorney takes effect if I become unable to make my own

health care decisions and this fact is certified, in writing, by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent, but you may do so. An alternate agent may make the same health care decisions as the designated agent, if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law, if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

_____; and

_____.

The original of this document is kept at:

_____

_____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

DURATION

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

(IF APPLICABLE) This power of attorney ends on the following date: Not applicable.

PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this medical power of attorney on _____ day of _____, 20__ at

_____ (City, State).

_____

_____
(Print Name)

STATEMENT OF FIRST WITNESS

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____ Print Name: _____

Date: _____ Address: _____

_____

SIGNATURE OF SECOND WITNESS

Signature: _____ Print Name: _____

Date: _____ Address: _____

_____

720119v1

INFORMATION CONCERNING THE
MEDICAL POWER OF ATTORNEY
[Disclosure Statement]

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over

your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;

(2) a person related to you by blood or marriage;

(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;

(4) your attending physician;

(5) an employee of your attending physician;

(6) an employee of a health care facility in which you are a patient, if the employee is providing direct patient care to you or is an officer, director, partner or business office employee of the health care facility or of any parent organization of the health care facility; or

(7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

720119v1

Directive to Physicians and Family or Surrogates (Texas)

This form is the preferred Living Will for a Texas resident. The Directive is an additional document to be used in Texas, since the statutory Medical Power of Attorney does not include the provisions commonly found in a Living Will.

[Texas]

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Instructions for completing this document:

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

DIRECTIVE

I, _____,

recognize that the best health care is based upon a partnership of trust and communication with

my physician. My physician and I will make health care decisions together as long as I am of

sound mind and able to make my wishes known. If there comes a time that I am unable to make

medical decisions about myself because of illness or injury, I direct that the following treatment

\preferences by honored:

If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

_____ I request that all treatments other than those needed to keep me

comfortable be discontinued or withheld and my physician allow me to die as gently as possible;

OR

_____ I request that I be kept alive in this terminal condition using available

life-sustaining treatment.

(THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

If, in the judgment of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care:

_____ I request that all treatments other than those needed to keep me

comfortable be discontinued or withheld and my physician allow me to die as gently as possible;

OR

_____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment.

(THIS SELECTION DOES NOT APPLY TO HOSPICE CARE.)

Additional requests: (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____

_____

_____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Dated: _____, 20____.

Signed: _____

City, County, State of Residence: _____

_____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as Witness 1 may not be a person designated to make a treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1: _____

Witness 2: _____

Definitions

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:

(1) that may be treated, but is never cured or eliminated;

(2) that leaves a person unable to care for or make decisions for the person's own self; and

(3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

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DURABLE POWER OF ATTORNEY
FOR
FINANCIAL MATTERS

I, _____, known in religion as

_____, OSU, as Principal, of the

County of _____, State of _____, do hereby name, constitute and appoint the person who occupies the office of Provincial Treasurer of the Ursuline Provincialate, Central Province of the United States, and each of her successors in said office as my true and lawful Attorney in Fact for as long as she holds said office (hereinafter the person who occupies the office of Provincial Treasurer, and each of her successors in said office, is referred to as my "Agent"), **such appointment to be effective ONLY upon my incapacity (as hereinafter defined)**. My Agent is hereby authorized to do and perform the acts herein described, for me and in my name, as fully and for all intents and purposes as I might or could do for myself if personally present and able.

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT SHALL BECOME EFFECTIVE IF I BECOME INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

11. POWERS GRANTED TO MY AGENT

I hereby confer upon my Agent general powers relating to all subjects and purposes, pursuant to the Durable Power of Attorney Law of the state in which I reside, including, but not limited to, the following powers, each of which may be exercised by my Agent in my Agent's sole and absolute discretion:

11.1. Public Assistance and Other Benefits

To apply on my behalf for any and all public assistance and aid programs, including but not limited to Medicaid and Social Security benefits, and I designate my Agent acting hereunder as my Personal Payee with respect to any Social Security payments or benefits to which I may be entitled, to access any of my personal Social Security records or other records relating to such programs, and to act on my behalf in every regard with respect to such matters.

11.2. Access to Safe Deposit Box

To access at all times any safe deposit box which I may own, and remove for my benefit any of the contents thereof and place any papers, securities, documents, or other valuables in any such safe deposit box.

11.3. Buy and Sell Property

To buy, sell, surrender for redemption, exchange, rent, lease, sublease, pledge, mortgage, hypothecate, or otherwise acquire, dispose of, or encumber, any property or interest therein (whether real, personal, or mixed, tangible or intangible) including but not limited to United States Savings Bonds, United States Treasury Bonds and Notes, and other obligations or securities issued or insured by the United States government or by any agency of, or corporation owned or controlled by, the United States government, common and preferred stocks, corporate, municipal and other bonds and debentures and any other investment security; to draw or endorse promissory notes and negotiable instruments; to contract a loan, acknowledge or make remission of a debt or become a surety; and to deal with such property upon such terms and conditions as my Agent shall determine is appropriate and to execute, acknowledge and deliver such instruments of assignment or transfer or any other documents as may be necessary to carry out the authority herein granted.

11.4. Buy and Sell Real Property

To sell and convey any real estate now owned or hereafter acquired by me for such price and on such terms and conditions as my Agent in my Agent's sole discretion shall deem advisable, including the power to sell for other than all cash and the power to take and accept a promissory note secured by a deed of trust for part of the purchase money, and to execute any and all contracts with respect to such sale and any modifications thereof, and any and all other agreements, documents and instruments which may be necessary to exercise the powers granted under this paragraph, including, without limitation, the power to execute, acknowledge, and deliver good and sufficient deeds and conveyances for the said real estate or any portion thereof with or without covenants and warranty, including the power to execute deeds with full warranties or special warranties, and to execute affidavits with respect to the presence or absence of adverse possessory rights and/or liens for work, labor, or material furnished to same, and to approve closing statements and to authorize the payment out of the proceeds of any such sale of the said real estate deemed appropriate by my Agent in connection with any such sale and the closing of any such sale.

11.5. Collect Money

To ask, demand, sue for, collect and receive all sums of money, dividends, interest, rent, payments on account of debts and legacies, and any and all other property now due or which may hereafter become due and owing to me, and execute good and valid receipts and charges for any such payments.

11.6. Court Decisions

To make any and all decisions on my behalf with regard to any court proceedings, litigation, arbitration, or dispute resolution of any type of which I may be a party; to initiate, defend, or prosecute such proceedings on my behalf with regard to the pursuit of any claim or cause of action which my Agent believes should be pursued on my behalf in my Agent's sole discretion; to refer a matter to arbitration; and to enter any settlement agreement or compromise with regard to any such proceedings.

11.7. Checking and Other Accounts

To make, execute, and sign checks and withdrawal requests against any checking accounts, savings accounts, certificates of deposit, and/or other accounts which I may own or hereafter hold in my name at any bank, savings and loan association, or other financial institution of any kind whatsoever.

11.8. Assign, Pledge or Liquidate Accounts

To assign, pledge or cash in any and all certificates of deposit and/or the balances in any checking, savings, and/or other accounts which I may have, and may use the proceeds therefrom or reinvest the same for my benefit in such manner as is determined in my Agent's discretion.

11.9. Open and Create Accounts

To open any checking accounts, savings accounts, and/or other accounts in my name at any bank, savings and loan association, or other financial institution, and to invest in my name in certificates of deposit at any such institution which my Agent deems appropriate or advisable.

11.10. Endorse Instruments

To endorse any and all checks, drafts, notes, certificates of deposit, or other evidences of indebtedness, payable in whole or part to me, receive and receipt for any and all sums of money called for in any such checks, drafts, notes, certificates of deposit, or other written obligations, payable in whole or in part to me, and cash or deposit for collection any checks, drafts, notes, certificates of deposit, or other evidences of indebtedness. My Agent may ask for, have paid to my Agent on my behalf, demand, sue for, recover, collect, and receive and receipt for all such sums of money, debts, accounts, interests, dividends, annuities, and demands of any kind as now are or hereafter shall become due, owing, or payable to me. The powers conferred by this paragraph are intended to complement and supplement all of the powers conferred upon my Agent by this instrument so that all amounts due or payable to me from every source and every nature may be collected for me by my Agent.

11.11. Prepare and Sign Tax Returns

To prepare (or have prepared by competent persons) and sign on my behalf and in my name any and all tax returns, whether federal, state and/or local, which may be required to file at any time; file claims for refund, request for extension of time, execute waivers and consents in my name; execute petitions to the Tax

Court of the United States and to cause me to be represented in any such proceedings; pay from my funds any taxes which my Agent reasonably believes are due any governmental authority; receive on my behalf any refunds of tax which may be due to me; and represent me in all income tax and other tax matters before all offices and officers of the Internal Revenue Service or the Treasury Department or the tax offices, officials or bureaus of any state, county or municipality, or of any other nation.

11.12. Dispose of Property

To acquire, rent, lease, alienate, mortgage, encumber, pledge, sell or otherwise dispose of any and all property now or hereafter owned by me (whether real or personal) and to execute, acknowledge, and deliver such deeds, leases, mortgages, bills of sale, security interests, or other instruments of transfer as may be necessary to accomplish the foregoing purposes. My Agent may collect and receipt for any money, property, or other consideration received in any such transaction.

11.13. Manage Real Property

To take possession of and/or manage any real property of mine.

11.14. Arrange for Personal Care

To make any and all arrangements deemed appropriate and in my best interests for my personal care, support, maintenance, living arrangement, medical, surgical, or dental care; to sign, execute, acknowledge, and deliver for me and in my name any and all instruments deemed by my Agent to be in my best interests or necessary or appropriate to carry out the authority herein vested; and to engage physicians, surgeons, dentists, nurses, or other individuals, and engage any institutions, as may be deemed necessary or appropriate in order to render to me any of the types of care hereinabove referred to.

11.15. Annuity Powers

To assign, elect options under, borrow against, redeem, surrender, exchange, cancel and pay any premiums due under any annuity contract or contracts providing for payments to me during my lifetime or to a beneficiary, upon or following my death.

11.16. Engage Attorneys and Other Agents

To engage on my behalf the services of such attorneys at law, accountants, or other professional persons as my Agent may, from time to time, deem reasonable and appropriate in connection with the handling of my personal affairs or in connection with the performance of my Agent's duties and functions as set forth herein.

11.17. Personal Property Powers

To sell, exchange, convey and mortgage any part or parts of my personal property (including, but not limited to, any automobiles) owned by me for such consideration and upon such terms as my Agent may deem adequate and proper;

execute and deliver any contracts or other instruments relating to my affairs, including, but not limited to, contracts or other instruments relating to the sale, purchase, encumbrance, partitioning or other dealing with real or personal property and/or relating to carrying out the terms of any contracts previously executed by me or on my behalf; take all steps and remedies necessary and proper for the conduct and management of my business affairs; accept or renounce a succession; place in effect insurance policies, and execute documents in support thereof and give releases in connection therewith; make such payments and expenditures out of my funds as may be necessary in connection with the exercise of any of the matters described herein or the administration of my affairs; appear for me in all actions and proceedings to which I may be a party in the courts of any state or the United States, or in the courts of any other nation, or in any administrative proceeding; commence or defend actions and proceedings in my name if necessary, and to sign and verify in my name all complaints, petitions, answers and other pleadings of every description.

11.18. Transfers to Trusts

To transfer any of my real or personal property to any trust of which I am a grantor.

11.19. Disclaimer Powers

To disclaim on my behalf any property or interest in property and take all actions and execute all documents on my behalf necessary to cause any such disclaimer to be a "qualified disclaimer" for purposes of the Internal Revenue Code.

11.20. Shareholder Powers

To attend and represent me whenever and wherever at any and all annual and/or special shareholders' meetings and/or any other meetings, gatherings, and/or events to which I, as a shareholder, officer, partner, owner and/or member of any corporation, partnership, association or other entity, am required, entitled and/or permitted to attend.

11.21. Other Ownership Powers

To do any and all other things and exercise any and all other rights which I, as a shareholder, partner, owner and/or member of any corporation, partnership, association or other entity may be entitled pursuant to law or otherwise.

11.22. Benefit Plan Powers

To assign, elect options under, request or accept distributions under, and otherwise deal with any pension plan, profit-sharing plan, Keogh Plan, Individual Retirement Account or similar benefit plan, or any other similar plan or arrangement.

11.23. Necessary, Incidental and Other Powers

To do and perform any and all other acts and things necessary or incidental to the performance and execution of the powers herein expressly granted in order to

fully carry out and effectuate the authority herein granted, as fully to all intents and purposes as I might or could do if personally present and personally acting.

12. GENERAL POWER OF ATTORNEY

This instrument shall be construed and interpreted as a general power of attorney for all subjects and purposes, except as otherwise herein expressly limited. The listing and designation of specific items, rights, acts or powers herein shall not limit or restrict, and is not to be construed or interpreted as limiting or restricting, the general powers herein granted to my Agent.

13. POWERS RELATING TO EXECUTION OF MY ESTATE PLANNING DOCUMENTS

Anything herein to the contrary notwithstanding, my Agent shall have no authority to change my domicile or residency, if such a change would expand the authority of my Agent. If my domicile or residency changes, I hereby confer upon my Agent the authority to object to any attempt to revoke or amend any of my estate planning documents.

14. REVOCATION OF PRIOR POWERS OF ATTORNEY

I hereby revoke and cancel any and all powers of attorney previously made by me for any of the purposes set forth herein, except my most recent Durable Power of Attorney granting general powers relating to my health care and physical care, which has either been executed previously by me or contemporaneously with the execution of this Durable Power of Attorney.

15. MODIFICATION, REVOCATION

I hereby reserve the right, by subsequent instrument in writing, to modify or revoke this Durable Power of Attorney.

16. TERMINATION OF AUTHORITY

My Agent shall have no authority to act under this document after my death, except as permitted by law.

17. EXPENSE OF AGENT

My Agent shall be entitled to reimbursement for all reasonable and necessary expenses incurred by my Agent in performance of the powers and functions set forth herein.

18. SUCCESSOR AGENTS

Each person who succeeds to the office of Provincial Treasurer of the Ursuline Provincialate, Central Province of the United States shall be my Agent, having all the powers granted hereunder for as long as she holds said office

19. DEFINITION OF INCAPACITY

I recognize and intend that this Durable Power of Attorney shall become effective and continue in full force during my incapacity to the extent provided in the Durable Power

of Attorney Law of the state in which I reside. For purposes of this instrument, my incapacity shall be deemed to exist in either of the following circumstances:

19.1. Physician's Certification

When two physicians, one of whom is my attending physician, certify in writing that in their opinion I am physically or mentally incapable of managing my financial affairs and/or providing for my personal care. If this Durable Power of Attorney becomes effective because of my incapacity and I subsequently regain capacity (which shall be deemed to occur when two physicians, one of whom is my attending physician, certify in writing that in their opinion I am physically and mentally capable of managing my financial affairs), then this Durable Power of Attorney shall not be revoked but shall become effective again upon my subsequent incapacity determined as provided above. I hereby waive voluntarily any physician/patient privilege that may exist in my favor and I authorize the physicians to examine me and disclose my physical or mental condition in order to determine my incapacity or capacity, for purposes of this instrument; provided, however, that the physicians who so certifies my incapacity need not incorporate the certification into my records, set forth the facts upon which the determination of incapacity is based, set forth the expected duration of my incapacity, or periodically review their determination of incapacity unless requested to do so in any such case by my Agent designated herein; or

19.2. Other Circumstances

During any period in which I am missing under such circumstances that it is not known whether I am alive or dead, or am captured, interned, besieged or held hostage or prisoner in a foreign country.

IN WITNESS WHEREOF, I have hereunto signed my name this _____ day of _____, 20___.

_____

_____, known in religion as

_____, OSU

The undersigned witnesses certify that _____, known in religion as _____, OSU, is personally known to us to be the same person whose name is subscribed as Principal to the foregoing Durable Power of Attorney, appeared before us and the notary public and acknowledged signing and delivering the instrument as the free and voluntary act of the Principal, for the uses and

purposes therein set forth. We believe that _____, known in religion as _____, OSU, is 18 years of age or older, is of sound mind and memory, and voluntarily signed this instrument in our presence.

Dated: _____, 20__

Witnesses:

_____

_____

STATE OF _____)
) ss.
COUNTY OF _____)

On this _____ day of _____, 20__, personally appeared before me _____, known in religion as _____, OSU, known to me to be the person described in and who executed the foregoing Durable Power of Attorney as Principal, and acknowledged that *he* executed the same as her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal, on the day and year first above written.

_____
Notary Public

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