Health Care Proxy 597460

(1) I, Kevin Eric Saunders 43391507

hereby appoint Alice H. Richardson
(name, home address and telephone number)
1668 Trumansburg Rd. Ithaca NY 14850 607-277-5808

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)
No "psychiatric" or other treatments not based on sound, evidence based science. No ECT. If Alice H. Richardson decides it is in my best interests to end my life in order to ease my suffering, she has my unqualified approval. She may decide matters of nutrition/[illegible] hydration.
(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on reverse for samples of language you could use.) I wish to be allowed a natural death. In addition, if no measurable brain activity appears a do-not-resuscitate order will be POSTED and RESPECTED.

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.
Jean Cox Saunders 242 Kingsrow Dr. Little Rock AR 72207
(name, home address and telephone number)
501-663-2121

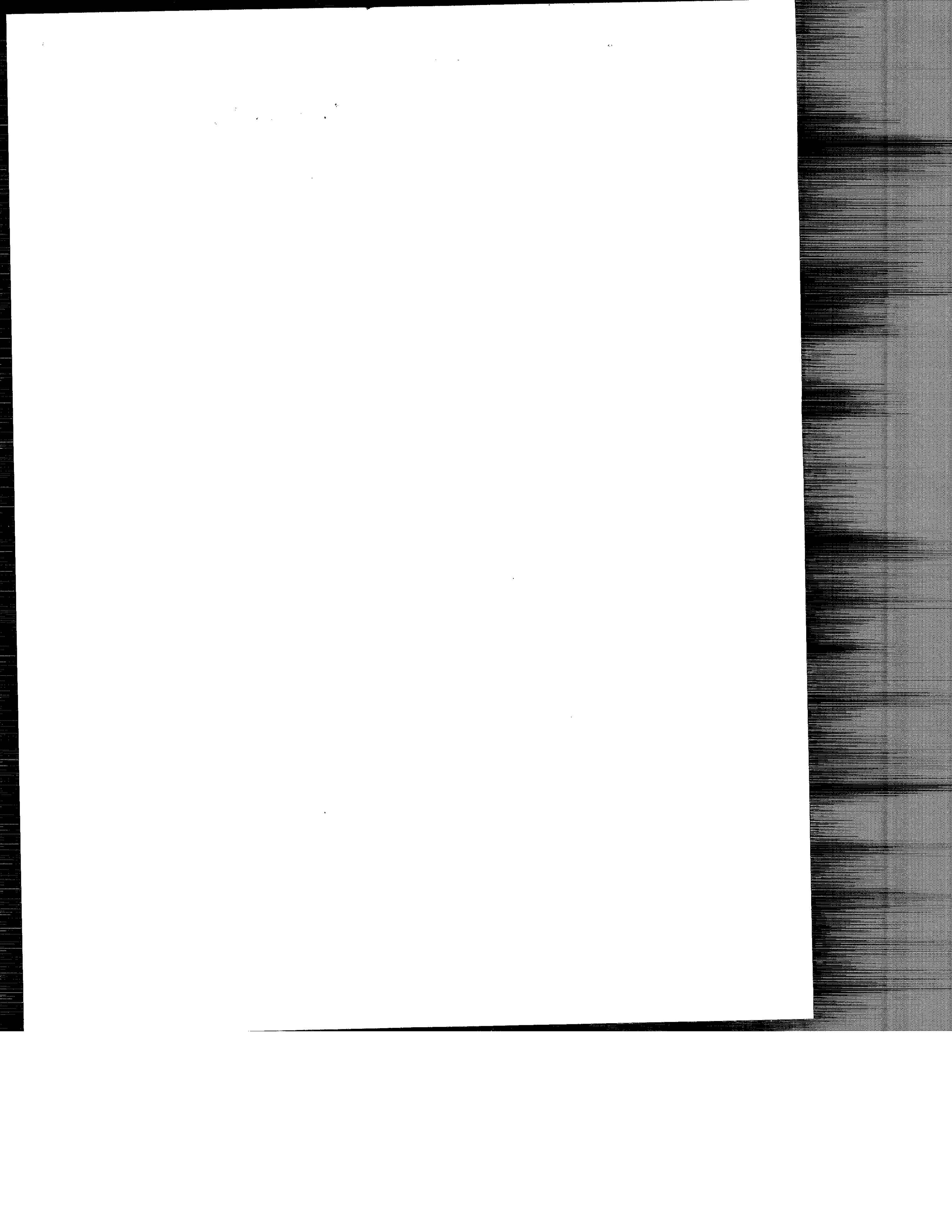
(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

(5) Signature [signature]
Address 1668 Trumansburg Rd.
Date 4/26/02

Statement by Witness (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 Yvonne J [illegible] - 101 Oakdale [illegible], Ithaca NY
Address
Witness 2 [signature] Martha W. Cohen
Address 2990 Parmenter Rd, Lodi, NY 14860



Mark Finnigan is a liar.
I hereby revoke this grant of his power to act as my health care proxy.
SIGNED — [signature] — Bonze Anne Rose Blayk — 1/20/15

REVOKED

Jan 20, 2015

Health Care Proxy

(1) I, Bonze Anne Rose Blayk

hereby appoint [illegible]
(name, home address and telephone number)
3[illegible] Colegrove Rd
[illegible] NY [illegible] 6[illegible]-34[illegible]-911

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint Christine M Finnigan
(name, home address and telephone number)
3783 Colegrove Rd.
Trumansburg, NY 14886 227-7764

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. [signature] 1/20/15

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: [illegible]

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: If these proxies determine it is in my best interests to allow my life to end in order to ease my sufferings, they have my approval. They may decide matters of nutrition and hydration. I wish to be allowed a natural death. In addition, if I display no measurable brain activity a do-not-resuscitate order will be posted.

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*
Your Name Bonze Anne Rose Blayk
Your Signature [signature] Date 3/28/13
Your Address [illegible]8 Trumansburg Rd., Ithaca NY 14[illegible]

(6) Optional: Organ and/or Tissue Donation
I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)
☑ Any needed organs and/or tissues
☐ The following organs and/or tissues
☐ Limitations

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature [signature] Date 3/28/13

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*
I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date 3/28	Date 3/28/13
Name of Witness 1 *(print)* JAY SKEZAS	Name of Witness 2 *(print)* Kevin Moss
Signature [signature]	Signature [signature]
Address 178[illegible] HANSHAW RD ITHACA, NY 14850	Address 2133 Mecklenburg Rd. Apt.3 Ithaca, NY 14850