

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

PROTECTIVE MEDICAL DECISIONS DOCUMENT

A.-DESIGNATION AND APPOINTMENT OF HEALTH CARE AGENT

I, _____ of _____ County, _____ State

shall hereby appoint:

Agent Name _____

Address _____

Phone _____

as my attorney in fact (herein called Agent) to make all health care and personal decisions for me if I become incapable to make such decisions on my own unless I state otherwise in this document.

B.-CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a Durable Power of Attorney for Health Care and shall take effect immediately upon my incapacity or disability and shall continue during such incapacity or disability.

None of the following persons may act as the agent for the principal: Any of the principal's physicians, the physicians' employees, or the owners, administrators, or employees of the health care facility or long-term care facility where the principal resides or receives care unless the above person is my approved family member.

C.-DESIGNATION OF ALTERNATE AGENT.

If the person designated as my Agent is not available or unable to act, I designate the following persons to serve as my Agents to make health care decisions for me as lawfully authorized by this document.

ALTERNATE AGENT #1

Agent Name: _____

Agent Address _____

Agent Phone _____

ALTERNATE AGENT #2

Agent Name: _____

Agent Address _____

Agent Phone _____

D.-STATEMENT OF AUTHORITY TO WITHHOLD OR WITHDRAW CONSENT

I grant to my Agent full power and lawful authority to make health care decisions for me to the same extent that I would make such decisions for myself if I had the capacity to do so, including the authority to direct the withdrawal or withholding of artificially provided food and nutrition. My Agent shall perform and honor all my established wishes and desires if I become incapacitated. In addition, my Agent shall make health care decisions that are consistent with my wishes and demands previously stated in this document or otherwise made known to my Agent.

E.-LIMITATIONS FOR DECISION MAKING AND AUTHORITY GRANTED TO MY AGENT

I DO NOT authorize or consent to any COVID19 tests, COVID19 vaccines, COVID19 procedures or any biologics whatsoever.

I DO NOT authorize or consent any use of a ventilator.

I DO NOT authorize or consent the use of the drug Remdesivir or any experimental drug, therapy or procedure.

I DO authorize the use of Ivermectin, Hydroxychloroquine and Vitamins C, D and Zinc infusions.

I DO authorize the use of Oxygen Therapy.

I DO authorize hydration and nutrition to sustain my survival. This shall only be determined by my Agent, and not be determined by any physician or health care provider.

I DO authorize any and all welfare checks performed by my Agent.

Upon the presence of any of the following symptoms: Breathing Problems, Low Oxygen Levels, Cough or Pneumonia.

It is my wish that my Agent authorize the administration of the following Protocol by Dr. Vladimir Zelenko:

Protocol :

Elemental Zinc 50-100mg once a day for 7 days

Vitamin C 1000mg 1 time a day for 7 days

Vitamin D3 10000iu once a day for 7 days or 50000iu once a day for 1-2 days

Azithromycin 500mg 1 time a day for 5 days or

Doxycycline 100mg 2 times a day for 7 days

Hydroxychloroquine (HCQ) 200mg 2 times a day for 5-7 days and/or

Ivermectin 0.4-0.5mg/kg/day for 5-7 days Either or both HCQ and IVM can be used, and if one only, the second agent may be added after about 2 days of treatment if obvious recovery has not yet been observed etc.

Dexamethasone 6-12mg 1 time a day for 7 days or

Prednisone 20mg twice a day for 7 days, taper as needed

Budesonide 1mg/2cc solution via nebulizer twice a day for 7 days

Blood thinners (i.e. Aspirin, Lovenox, Eliquis, Xarelto, Pradaxa)

IV fluids and Oxygen.

I currently make these demands having full mental capacity and of sound mind and under no duress, fraud, or undue influence and of my own free will.

F.-AUTOPSY, DISPOSITION OF REMAINS.

I authorize my Agent, to the extent permitted by law, to authorize an autopsy and/or toxicology test upon my demise and direct the disposition of my remains.

G.-NOMINATION OF GUARDIAN

I nominate my Agent (or Alternate Agent) to serve as my Guardian and Durable Power of Attorney for Health Care. I authorize Agent to participate in court proceedings on my behalf regarding the validity of this document and the acts of the Agent, including the initiation or participation in declaratory relief actions for injunctions and actions for damages against persons who negligently or knowingly and willingly refuse to comply with the wishes and instructions of my Agent.

H.-REVOCATION OF PRIOR ADVANCE HEALTH CARE DIRECTIVES

I revoke any prior advance Health Care Directives. There is a lawful obligation to perform under this contract that all my wishes and procedures are adhered to with dignity and not concurrent to unlawful procedures and mandates.

I.-NO LIABILITY FOR UNKNOWN REVOCATION OR AMENDMENT

Hold Harmless All persons who act in good faith to carry out my wishes and the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising from their action or inaction based on this document. My estate shall defend and indemnify them.

Intentions It is my statement of lawful authority under God and my spiritual obligations that this document shall be lawfully and legally binding. It is the sworn duty of the state to certify and bring forth valid evidence that they have achieved my lawful consent for any and all contractual agreements of the binding consequences which may hereby be in utter violation and repercussions of my wishes and demands in accordance to the letter of well-established law that shall provide remedy by all those acting contrary to my demands, stipulations and violation of trust. You are hereby given notice of your obligations and your liabilities to perform under contract law and trust.

Photocopies of this document, after it is signed, notarized and witnessed, shall have the same legal and lawful force as the original document.

I voluntarily sign this Durable Power of Attorney for Health Care after careful consideration and am fully aware of its meaning and accept its consequences. I have thoroughly read the contents of this document and the effect that I grant to my Agent. I am not under any duress and am of sound mind to make this lawful declaration.

Signed on this _____ day of _____, 2021

Signature _____

Printed Name _____

Address: _____

Date of Birth _____

WITNESSES

I declare that _____ who signed or acknowledged this document (the principal) has identified himself or herself to me, that he/she signed or acknowledged this document in my presence and appears to be of sound mind and under no duress, fraud, coercion or undue influence I am not the person that has been appointed as Agent by this document. I seek no financial or material gain by witnessing and signing this Durable Power of Attorney for Health Care.

Witness

Signature: _____

Name: _____

Address: _____

Date: _____

Witness

Signature: _____

Name: _____

Address: _____

Date: _____

NOTARY STATEMENT

In the State of _____

County of _____

I swear that on this _____ day of _____, 2021

the above-named principal _____

personally, appeared before me, of his/her own free will and of sound mind, signed and executed this
Durable Power of Attorney for Health Care.

WITNESS my hand and official seal.

Notary Public Signature

Seal: