ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

NOTICE AND WARNING TO PERSON EXECUTING THIS DOCUMENT --

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CAN CONTROL IMPORTANT DECISIONS ABOUT YOUR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

FACTS ABOUT PART B (APPOINTING A HEALTH CARE REPRESENTATIVE)

YOU HAVE THE RIGHT TO NAME A PERSON TO DIRECT YOUR HEALTH CARE WHEN YOU CANNOT DO SO. THIS PERSON IS CALLED YOUR "HEALTH CARE REPRESENTATIVE." YOU CAN DO THIS BY USING PART B OF THIS FORM. YOUR REPRESENTATIVE MUST ACCEPT PART E OF THIS FORM.

YOU CAN WRITE IN THIS DOCUMENT ANY RESTRICTIONS YOU WANT ON HOW YOUR REPRESENTATIVE WILL MAKE DECISIONS FOR YOU. YOUR REPRESENTATIVE MUST FOLLOW YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN. IF YOUR DESIRES ARE UNKNOWN, YOUR REPRESENTATIVE MUST TRY TO ACT IN YOUR BEST INTEREST. YOUR REPRESENTATIVE CAN RESIGN AT ANY TIME.

FACTS ABOUT PART C (GIVING HEALTH CARE INSTRUCTIONS)

YOU ALSO HAVE THE RIGHT TO GIVE INSTRUCTIONS FOR HEALTH CARE PROVIDERS TO FOLLOW IF YOU BECOME UNABLE TO DIRECT YOUR CARE. YOU CAN DO THIS BY USING PART C OF THIS FORM.

FACTS ABOUT COMPLETING THIS FORM

THIS FORM IS VALID ONLY IF YOU SIGN IT VOLUNTARILY AND WHEN YOU ARE OF SOUND MIND. IF YOU DO NOT WANT AN ADVANCE DIRECTIVE, YOU DO NOT HAVE TO SIGN THIS FORM.

UNLESS YOU HAVE LIMITED THE DURATION OF THIS ADVANCE DIRECTIVE, IT WILL NOT EXPIRE. IF YOU HAVE SET AN EXPIRATION DATE, AND YOU BECOME UNABLE TO DIRECT YOUR HEALTH CARE BEFORE THAT DATE, THIS ADVANCE DIRECTIVE WILL NOT EXPIRE UNTIL YOU ARE ABLE TO MAKE THOSE DECISIONS AGAIN.

YOU MAY REVOKE THIS DOCUMENT AT ANY TIME. TO DO SO, NOTIFY YOUR REPRESENTATIVE AND YOUR HEALTH CARE PROVIDER OF THE REVOCATION.

DESPITE THIS DOCUMENT, YOU HAVE THE RIGHT TO DECIDE YOUR OWN HEALTH CARE AS LONG AS YOU ARE ABLE TO DO SO. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, ASK A LAWYER TO EXPLAIN IT TO YOU.

YOU MAY SIGN PART B, PART C, OR BOTH PARTS. YOU MAY CROSS OUT WORDS THAT DON'T EXPRESS YOUR WISHES OR ADD WORDS THAT BETTER EXPRESS YOUR WISHES. WITNESSES MUST SIGN PART D.

Print your NAME, BIRTH DATE AND ADDRESS here:

Name: Cindy L Lund
Birth Date: 10-24-1956
Address: 556 CRESwood Loop
CReswell, OR. 97426

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:
CL My entire life
_____ Other period (Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

TO: My family, physicians and all those concerned with my care

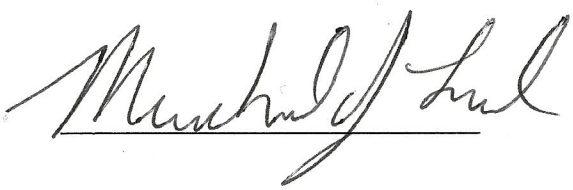
I, CINDY LEE LUND, hereby appoint and authorize my spouse, MICHAEL JON LUND, presently residing at 556 Creswood Loop, Creswell, Oregon 97426, tel. no.: (541) 513-0731, as my health care representative to act for me and in my name to make and communicate any and all decisions about or relating to my receipt or refusal to accept medical treatment, diagnostic procedures, surgery, hospitalization, care and treatment in a nursing home or other facility, health care, nursing care or personal care, in any situation in which, as the result of illness, disease, mental deterioration or injury, I am incapable of making or communicating a decision with respect to my treatment or care. This authorization includes the right to refuse and direct the withdrawal of medical treatment which would prolong my life, and to communicate health care decisions to all persons including without limitation my physicians, health care providers and family.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative for CINDY LEE LUND. I understand that I must act consistently with the desires of CINDY LEE LUND, as expressed in this document or otherwise made known to me. I understand that this document allows me to decide about the health care of CINDY LEE LUND only while she cannot do so. I understand that CINDY LEE LUND may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the current health care provider of CINDY LEE LUND, if known to me.

I understand the above conditions and I accept the designation as health care representative for CINDY LEE LUND.

Dated: 9-7-2017



1. Limits. Special Conditions or Instructions:

None

INITIAL IF THIS APPLIES:
CL I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support. "Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:
CL My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding. One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:
CL My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

I further delegate to my health care representative the power and authority to select, employ and discharge health care personnel, such as physicians, nurses, therapists, hospice care and home health care providers, and other medical professionals; to admit or discharge me (including transfer from another facility) from any hospital, hospice, nursing home, adult home or other medical care facility; to apply for public benefits to defray the cost of health care; and to contract in my name and on my behalf for all health care services, including without limitation medical, nursing and hospital care, as my health care representative may deem appropriate. I confirm that I shall be and remain personally liable for the payment of all such care and services to the same extent as if I had personally contracted therefor.

I authorize my health care representative to donate all or any part of my body for transplantation, or to otherwise direct the disposition of my remains.

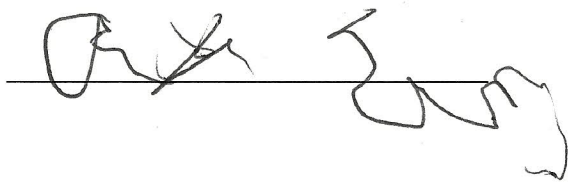
I grant to my health care representative the authority and power to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, the regulations in 45 C.F.R. Sec. 160 et seq., and any other applicable federal, state or local laws or regulations (collectively "HIPAA"), including the authority to request, receive, obtain and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or records referred to in 45 C.F.R. Sec. 164.501 and regulated by the Standards for Privacy of Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under HIPAA. I understand that health and medical records

can include information relating to subjects such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol or drug abuse or addiction. I understand that I may have access to or receive an accounting of the information to be used or disclosed as provided in 45 C.F.R. Sec. 164.524 et seq. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my health care representative to execute any and all releases or other documents that may be necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

I authorize my health care representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my health care representative is authorized to make pursuant to this document, including without limitation all documents pertaining to a refusal to permit medical treatment, or authorizing the leaving of a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider.

Date: 9-7-, ~~2016~~ 2017

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE:



PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

--The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.

--"Life support" and "tube feeding" are defined in Part B above.

--If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.

--You will get care for your comfort and cleanliness, no matter what choices you make.

--You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
__CL__ I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
__CL__ I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
__CL__ I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
__CL__ I want NO life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
__CL__ I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
__CL__ I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:
_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
CL I DO NOT WANT tube feeding.

B. INITIAL ONE:
_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
CL I want NO life support.

5. General Instruction.

INITIAL IF THIS APPLIES:
CL I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions.

None

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

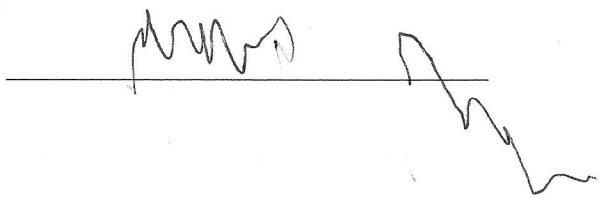
INITIAL ONE:

_____ I have previously signed a power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.
_____ I have a health care power of attorney, and I REVOKE IT.
CL I DO NOT have a health care power of attorney.

If any provision of this document is held to be invalid or unenforceable, the remainder of this document shall continue in full force and effect.

Dated: 9-7-___, ~~2016~~ 2017

SIGN HERE TO GIVE INSTRUCTIONS:



PART D: DECLARATION OF WITNESSES

WITNESS:

We, the witnesses whose names are signed below, each hereby attest and declare under penalty of perjury under the laws of the State of Oregon that: (1) the foregoing instrument was personally signed by in my presence, and thereupon I, at his request and in his presence and in the presence of the other witnesses, have hereunto subscribed my name as a witness; (2) I did not sign the above signature of for or at his direction; (3) I personally know (or the identity of was proven by proper military identification or other satisfactory proof) and believe him to be of sound mind and under no constraint, duress, fraud or undue influence; (4) I am not related to by blood, marriage or adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of the estate of upon his death under any will or codicil of or by operation of law; (6) I do not have any present or inchoate claim against any portion of the estate of ; (7) I do not have any financial responsibility for the medical care of ; (8) I am not a physician or an employee of any physician, and I am not an operator or employee of, or patient in, any hospital, health care provider, residential care facility, community care facility, skilled nursing facility or similar institution; (9) I am not a person named as health care representative in this instrument; and (10) are both at least 18 years of age (or are in the military service).

Dated: 9 8, 2016

Michele Taylor
print:

having an address at

105 West D Street
Springfield, OR 97477

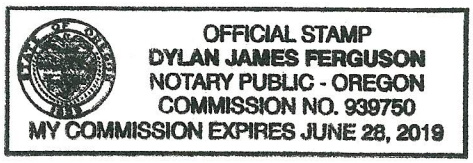
Sheila Rothermund
print:

having an address at

32463 Wilson Crk Rd
Cottage Grove, OR 97424

STATE OF OREGON, COUNTY OF LANE, ss.

The foregoing instrument was acknowledged before me on the 7 day of September, ~~2016,~~ 2017 by Cindy Lee Lund.



Notary Public
My commission expires on