INSTRUCTIONS TO COMPLETE & SIGN FORM

INSTRUCTIONS FOR FILLING OUT AND SIGNING ADVANCE HEALTH CARE DIRECTIVE

THIS FORM IS NOT FOR USE BY A PATIENT IN A SKILLED NURSING FACILITY

1. This document needs to be signed **EITHER** in front of a Notary Public licensed by the State **OR** two (2) witnesses, one of which can not be related to you by blood, marriage, or adoption, and they are not entitled to any part of the your estate. Your bank may notarize documents free of charge. Postal stores also typically have a Notary on staff. Bring a drivers license, your passport or some other reliable form of identification to prove your identity to the Notary.

2. **Be sure that the form is complete before you meet with the Notary**. There are several places where you can choose various alternatives or add additional thoughts and concerns. While you can refine your wishes in many areas on the form, in most cases only the following three items should be addressed. Be sure to at least check the following sections:

   1.3 WHEN EFFECTIVE: Review this section and consider whether or not you wish to initial to make the document currently effective. If you initial, this would allow your agent to use the form to communicate with your doctors whether or not you are incapacitated and collect and get access to medical records if they thought necessary. For example, it would allow your agent to freely speak with your doctor if the agent was concerned about your health and well-being. If you do initial, the form can only be used when your physician determines that you are unable to make your own healthcare decisions.

   2.1 END OF LIFE DECISIONS: Choose between (a) and (b) or modify 2.2 and/or 2.3 to accurately state your wishes regarding end of life decisions.

   3.1 ORGAN DONATION: Choose between (a), (b) and (c) or modify (d) to accurately state your wishes regarding organ donation.

   If you choose to donate, all uses of organs are permitted unless you line through one or more of the categories (Transplant, Therapy, Research or Education) that you don't want your organs used for. If you line through one or more categories, please add your initial next to each item you have lined out.

3. In Part 6 include the date and the county where you sign the document if its not already set forth.

4. In the presence of a Notary OR two (2) disinterested Witnesses, sign the document at Section 6. **DO NOT DO BOTH!** Print your name and address where indicated.

5. If Notarized, the Notary will then sign, date and affix the Notary Seal to the document. The Notary will then have you sign the Notary Journal, which records all signatures that have been notarized. If Witnessed, gather the two Witnesses with you at the same time and sign. Have both complete their contact information and print and sign their names at 6.3 **and** at least one disinterested witness must sign at 6.4.

6. Give a copy to your Agents and keep the original with your other estate planning documents. Bring a copy with you on any hospitalization.

7. Consult your attorney if you have any questions.

ADVANCE HEALTH CARE DIRECTIVE FORM

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(A) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
(B) Select or discharge health care providers and institutions.
(C) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
(D) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
(E) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

1.1 DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (ZIP Code)

_____
(home phone) (cell phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____
(name of individual you choose as first alternate agent)

_____
(address) (city) (state) (ZIP Code)

_____
(home phone) (cell phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____
(name of individual you choose as second alternate agent)

_____
(address) (city) (state) (ZIP Code)

_____
(home phone) (cell phone)

1.2 AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____
(Add additional sheets if needed.)

1.3 WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I initial here _____, my agent's authority to make health care decisions for me takes effect immediately.

1.4 AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.5 AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

1.6 NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

2.1 END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

_____ Initial

(a) Choice Not To Prolong Life:
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

_____ Initial

(b) Choice To Prolong Life:
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 RELIEF FROM PAIN: Except as I state in the following space, direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

(Add additional sheets if needed.)

2.3 OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

3.1 Upon my death (mark applicable box):

_____ (a) I do not desire to leave any anatomical gifts, OR
Initial

_____ (b) I give any needed organs, tissues, or parts, OR
Initial

_____ (c) I give the following organs, tissues, or parts only.
Initial

_____

_____

My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

_____

_____

_____

(Add additional sheets if needed.)

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

4.1 I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (ZIP Code)

_____
(phone)

PART 5
HIPAA

5.1 HIPAA RELEASE AUTHORITY: The undersigned grants to my agent, under my advance health care directive, the authority to advocate for my health care needs even if I have not been determined to lack capacity. Further, this release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent, without restriction and at my agent's request, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including, but not limited to, any and all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness (including information contained in mental health records protected by the Lanterman-Petris-Short Act), HIV/AIDS, and drug or alcohol abuse. This authority shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given to my agent shall expire in the event that I revoke this authority in writing and deliver it to my health care provider.

PART 6

6.1 EFFECT OF COPY: A copy of this form has the same effect as the original.

6.2 DATE AND SIGNATURE OF PRINCIPAL: I sign my name to this Statutory Form Advanced Health Care Directive on _____, 20__ at _____ County, California.

_____
(signature)
Print Name: _____
Address: _____
_____

THE SIGNING OF THIS DOCUMENT MUST BE WITNESSED BY TWO WITNESSES (*SEE 6.3 & 6.4 BELOW*)
OR
NOTARIZED

6.3 STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness:

Signature: _____ Residence Address Below:
Print Name: _____ _____
Date _____ _____

Second witness:

Signature: _____ Residence Address Below:
Print Name: _____ _____
Date _____ _____

6.4 ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Witness Signature:

_____

Witness Signature:

_____

NOTARY FORM BELOW FOR USE WHERE THIS FORM IS NOT WITNESSED

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document, to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN DIEGO)

On _____, 20___, before me, _____ , a notary public, personally appeared _____ who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or entity upon behalf of which the person acted, executed the instrument.

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

WITNESS my hand and official seal.

_____

(Signature)

(Seal)

SAMPLE COMPLETED FORM

ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4701)

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(A) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
(B) Select or discharge health care providers and institutions.
(C) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.
(D) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.
(E) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

1.1 DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Jane Doe
(name of individual you choose as agent)

101 13th St. Smallville CA 91111
(address) (city) (state) (ZIP Code)

(XXX) XXX-XXXX (YYY) YYY-YYYY
(home phone) (cell phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

JAmes Doe
(name of individual you choose as first alternate agent)

55 Smith Lane, Big Town, OH 45002
(address) (city) (state) (ZIP Code)

(XXX) XXX-XXXX
(home phone) (cell phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Blank
(name of individual you choose as second alternate agent)

(address) (city) (state) (ZIP Code)

(home phone) (cell phone)

1.2 AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

(Add additional sheets if needed.)

1.3 WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I initial here RS, my agent's authority to make health care decisions for me takes effect immediately.

1.4 AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.5 AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

1.6 NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

2.1 END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

RS
Initial

(a) Choice Not To Prolong Life:
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

_____
Initial

(b) Choice To Prolong Life:
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2 RELIEF FROM PAIN: Except as I state in the following space, direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

(Add additional sheets if needed.)

2.3 OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

3.1 Upon my death (mark applicable box):

_____ (a) I do not desire to leave any anatomical gifts, OR
Initial

RS (b) I give any needed organs, tissues, or parts, OR
Initial

_____ (c) I give the following organs, tissues, or parts only.
Initial

_____

_____

My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
~~(3) Research~~ RS
~~(4) Education~~ RS

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

_____

_____

_____

(Add additional sheets if needed.)

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

4.1 I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (ZIP Code)

_____
(phone)

PART 5
HIPAA

5.1 HIPAA RELEASE AUTHORITY: The undersigned grants to my agent, under my advance health care directive, the authority to advocate for my health care needs even if I have not been determined to lack capacity. Further, this release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC §1320d and 45 CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to, any physician, health care professional, dentist, health plan, hospital, nursing home, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent, without restriction and at my agent's request, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including, but not limited to, any and all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness (including information contained in mental health records protected by the Lanterman-Petris-Short Act), HIV/AIDS, and drug or alcohol abuse. This authority shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given to my agent shall expire in the event that I revoke this authority in writing and deliver it to my health care provider.

PART 6

6.1 EFFECT OF COPY: A copy of this form has the same effect as the original.

6.2 DATE AND SIGNATURE OF PRINCIPAL: I sign my name to this Statutory Form Advanced Health Care Directive on 3-12, 2020 at San Diego County, California.

Roger Smith
(signature)

Print Name: Roger Smith
Address: 10 Healthcare Lane
Happyville, CA 92222

THE SIGNING OF THIS DOCUMENT MUST BE WITNESSED BY TWO WITNESSES (*SEE 6.3 & 6.4 BELOW*) OR NOTARIZED

6.3 STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness:

Signature: Betty Jones — Residence Address Below:
Print Name: Betty Jones — 25 Healthcare Lane
Date 3-12-2020 — Happyville, CA 92222

Second witness:

Signature: Fred Jones — Residence Address Below:
Print Name: Fred Jones — 25 Healthcare Lane
Date 3-12-2020 — Happyville, CA 92222

6.4 ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Witness Signature:

Fred Jones

Witness Signature:

NOTARY FORM BELOW FOR USE WHERE THIS FORM IS NOT WITNESSED

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document, to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

STATE OF CALIFORNIA)
) ss.
COUNTY OF SAN DIEGO)

On _____, 20___, before me, _____ , a notary public, personally appeared _____ who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or entity upon behalf of which the person acted, executed the instrument.

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

WITNESS my hand and official seal.

_____
(Signature)

(Seal)