POWER OF ATTORNEY REVOCATION

Reference is made to certain power of attorney granted by Betty M Parcaut
James E Parcaut / Pamele J Abercrombie (Grantor) to (Attorney-in-Fact),
and dated August 14th, 2013.

This document acknowledges and constitutes notice that the Grantor hereby revokes, rescinds and terminates said power-of-attorney and all authority, rights and power thereto effective this date.

Signed under seal this 26 day of March, 2017.

Betty M Parcaut
Printed Name of Grantor

Betty Parcaut
Signature of Grantor

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Colorado

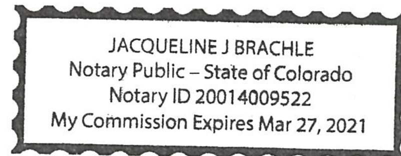
County of Arapahoe

On 3-26-17 before me, Jacqueline J. Brachle (here insert name and title of the officer), personally appeared Betty M. Parcaut, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

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

WITNESS my hand and official seal.

Jacqueline J Brachle
Signature (Seal)



POWER OF ATTORNEY REVOCATION

Reference is made to certain power of attorney granted by Betty Marie Jacoby (Grantor) to STATE OF COLORADO (Attorney-in-Fact), and dated OCTOBER 27, 20 1961

This document acknowledges and constitutes notice that the Grantor hereby revokes, rescinds and terminates said power-of-attorney and all authority, rights and power thereto effective this date.

Signed under seal this 27 day of June, 20 17.

Betty Parcaut/Jeffrey Nordloh
Printed Name of Grantor

Betty Parcaut / Jeffrey Nordloh POA
Signature of Grantor

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Colorado

County of Jefferson

On 06/27/2017 before me, Lynzie Padilla, Notary Public (*here insert name and title of the officer*), personally appeared Jeffrey Nordloh, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

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

WITNESS my hand and official seal.

Lynzie Padilla
Signature

(Seal)

Lynzie Paige Padilla
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 20154040942
MY COMMISSION EXPIRES October 16, 2019

CERTIFICATION OF VITAL RECORD

STATE OF COLORADO

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

HOLD TO LIGHT TO VIEW WATERMARK

CERTIFICATE OF LIVE BIRTH

STATE FILE NUMBER
1051961036420

NAME OF REGISTRANT
JEFFREY ROBERT NORDLOH

DATE AND TIME OF BIRTH
OCTOBER 27, 1961 01:30 AM

GENDER OF REGISTRANT
MALE

CITY OF BIRTH
DENVER

COUNTY OF BIRTH
DENVER

MOTHER'S NAME PRIOR TO FIRST MARRIAGE
BETTY MARIE JACOBY

MOTHER'S PLACE OF BIRTH
COLORADO

MOTHER'S AGE AT TIME OF BIRTH
25

FATHER'S NAME
PAUL MARTIN NORDLOH

FATHER'S PLACE OF BIRTH
COLORADO

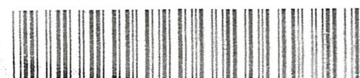
FATHER'S AGE AT TIME OF BIRTH
29

DATE RECORD FILED
NOVEMBER 07, 1961

DATE ISSUED JANUARY 17, 2012

THIS IS A TRUE CERTIFICATION OF NAME AND FACTS AS RECORDED IN THIS OFFICE. Do not accept unless prepared on security paper with engraved border displaying the Colorado state seal and signature of the Registrar. PENALTY BY LAW, Section 25-2-118, Colorado Revised Statutes, 1982, if a person alters, uses, attempts to use or furnishes to another for deceptive use any vital statistics record. NOT VALID IF PHOTOCOPIED.

Ronald S. Hyman
RONALD S. HYMAN
STATE REGISTRAR



REV 01/07

American Bank Note Company

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

COLORADO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

( )

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 when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have 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 cannot consent or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy unless the failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your agent or alternate agent or any person ineligible to be your agent. You may attach additional pages if you need more space to complete your statement.

If you want to give your agent authority to withhold or withdraw the artificial providing of nutrition and fluids, your document must say so. Otherwise, your agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had if made consistent with state law. It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which 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 and must be at least 18 years old. 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 will have 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 him or her 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 will have signed copies. Your agent will not be 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 him or her or your health care provider orally or in writing. 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 should consider designating an alternate agent in the event that your agent is unwilling, unable, unavailable, or ineligible to act as your agent. Any alternate agent you designate will have the same authority to make health care decisions for you.

1. DESIGNATION OF HEALTH CARE AGENT.

I, Betty Parcaut 1050 S Garrison st Lakewood Co 80226
(Insert your name and address)
do hereby designate and appoint Jeffrey Nordloh
1050 S Garrison st Lakewood Co 80226 303-988-9229

(Insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.)

as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires

concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated. Additional statement of desires, special provisions, and limitations: None

____

____

____

____ [None or State limitations].

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign each of the additional pages at the same time you date and sign this document.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(d) Consent to the donation of any of my organs for medical purposes.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. DESIGNATION OF ALTERNATE AGENTS.

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or

ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent

Connie K Laird 10450 W Virginia Ave Ph 303 988-9229
(Insert name, address, and telephone number of first alternate agent)

B. Second Alternate Agent

Pamela J Abercrombie 11665 W Zeinobia Ct Westminster Co 80031 Ph 303-330-9793
(Insert name, address, and telephone number of second alternate agent)

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(You Must Date and Sign This Power of Attorney)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on 26th day of March 2017 at Lakewood Co.
(Date) (City) (State)

[signature]
(You sign here)

(This Power of Attorney will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature OR signed before a notary public. It is recommended that you have both the witnesses and the Notary sign the document. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this Power of Attorney.)

STATEMENT OF WITNESSES

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility, (6) your spouse, or (7) your lawful heirs or beneficiaries named in your will or a deed. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of Colorado [state] that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, my spouse, or my lawful heirs or beneficiaries named in a Will or deed.

Signature: Betty Parcant

Print name: Betty Parcant

Date: ____________ Residence address: ____________

Signature: ____________

Print name: ____________

Date: ____________ Residence address: ____________

(At least one of the above witnesses must also sign)

I further declare under penalty of perjury under the laws of ____________ [state] that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: ____________

Signature: ____________

NOTARY

(Notary is also recommended.)

State of Colorado,
County of Arapahoe

On this 26 day of MARCH 20/17 before me, JACQUELINE J. BRACHLE (insert title of acknowledging officer)
personally appeared BETTY M. PARCANT (full name of signer of instrument) to me known (or proved to me on basis of satisfactory evidence) to be the person who is named in and who executed the foregoing instrument and acknowledged that he/she executed same as his/her own voluntary act and deed.

Jacqueline J. Brachle
Notary Public in State of Colorado

Print Name of Notary: JACQUELINE J. BRACHLE

My Commission Expires: 3-27-2021