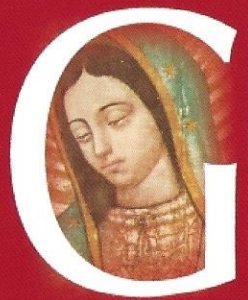

Life Guardian FOUNDATION

To protect and preserve God-given life from conception until true death

MEDICAL CARD TO PROTECT AND PRESERVE LIFE
MUST BE SIGNED AND WITNESSED BY TWO WITNESSES AND CARRIED WITH YOU AT ALL TIMES

WWW.LIFEGUARDIANFOUNDATION.ORG

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INSTRUCTIONS TO COMPLETE POWER OF ATTORNEY FOR HEALTH CARE

On page 2 of 3:

You are the Principal. Print your full name.
Print your birth date on the next line.
Print full name of primary health care representative serving as agent.
Primary health care representative serving as agent must sign and date this page.
Fill in phone numbers for primary health care representative serving as agent.
Print full name of secondary health care representative serving as agent.
Secondary health care representative serving as agent must sign and date.
Fill in phone numbers for secondary health care representative serving as agent.
You, the Principal must sign and date on line for Signature of Principal and Date.
Have two witnesses observe you sign and date this document.
Neither witness may be related to you or have a claim on your estate.
Neither witness may be a health care provider serving you at this time.
Both witnesses must sign and date.

On page 3 of 3:

I, (then print your full name on blank line).
Sign and date principal line.
Have two witnesses observe you sign and date this document.
Neither witness may be related to you or have a claim on your estate.
Neither witness may be a health care provider serving you at this time.
Both witnesses must sign and date.
Tell your relatives that you have signed Power of Attorney for Health Care and Directions to Protect and Preserve your life and where the completed Notarized document can be found.

These Directions to Protect and Preserve Life must be kept wherever medical treatment and care will be given. Have several copies to give to doctor, hospital, nursing home, assisted living facility or the like. Also provide these Directions to Protect and Preserve Life for the primary and secondary decision-makers and close relatives.

After completion of these Directions to Protect and Preserve Life it is recommended that copies be given to family members so that these Directions to Protect and Preserve Life will be immediately available to prevent delay in treatment and care.

We recommend that these Directions to Protect and Preserve Life be notarized.

We recommend that you review these Directions to Protect and Preserve Life with your attorney. We are not attorneys.

* * * * *

DIRECTIONS TO PROTECT AND PRESERVE LIFE BY POWER OF ATTORNEY FOR HEALTH CARE

to be enforced by Health Care Representative Serving as Agent

This document records my Directions to Protect and Preserve Life to be enforced by my primary or secondary health care representative serving as agent. These Directions to Protect and Preserve Life must be held by caregivers and the primary and secondary health care representative serving as agent, as authorized, **AT ALL TIMES.**

In the event of a medical emergency and/or admission to hospital, nursing home, assisted living facility, or the like, the said authorized primary or secondary health care representative serving as agent, designated as indicated, must be contacted.

I, _____,
(print your full name on blank line)

wish to live the lifespan given by God. I direct that all medical and surgical treatments and care, including nutrition and hydration however administered, be given to protect and preserve my life. **Do not hasten death. Do not shorten life. Do not do an apnea test. Do not take any organ for transplantation or any other purpose.**

_____ _____
Signature of Principal Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Witness Date

I, _____, do solemnly swear that in my presence the foregoing document was signed by _____, on this _____ day of _____, 20__ under penalty of perjury. I state that this document is page three of three.

SUBSCRIBED AND SWORN to before me (Should be sealed here)
this _____day of _____, 20__.

_____
(signature of Notary Public) My commission expires [expiry date].

* * * * *

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Cut here along line

POWER OF ATTORNEY FOR HEALTH CARE

of

_____
Principal (print your full name)

_____
Principal (your date of birth)

I state that this is my Power of Attorney for Health Care and I revoke any prior Power of Attorney for Health Care signed by me. I understand the purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

This Power of Attorney for Health Care is in effect only when I cannot make health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

I designate my primary health care representative serving as agent, as authorized and indicated below, to direct and enforce **AT ALL TIMES** medical treatments and care in accord with these Directions to Protect and Preserve Life.

_____
Name of Primary Health Care Representative Serving as Agent (print full name)

_____ _____
Signature of Primary Health Care Representative Serving as Agent Date

PHONE NUMBERS:
Home: (___)_____-_____Office: (___)_____-_____Cell: (___)_____-_____

In the event that this primary decision-maker is not immediately available, or is unwilling or unable to communicate, I designate my secondary health care representative serving as agent to direct and enforce medical treatments and care in accord with these Directions to Protect and Preserve Life.

_____
Name of Secondary Health Care Representative Serving as Agent (print full name)

_____ _____
Signature of Secondary Health Care Representative Serving as Agent Date

PHONE NUMBERS:
Home: (___)_____-_____Office: (___)_____-_____Cell: (___)_____-_____

_____ _____
Signature of Principal Date

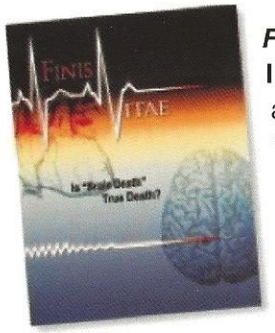
_____ _____
Signature of Witness Date

_____ _____
Signature of Witness Date

* * * * *

Life Guardian FOUNDATION

To protect and preserve God-given life from conception until true death



Finis Vitae,
Is "brain death" true death?
are the Proceedings of the "The Signs of Death" symposium conducted at the Pontifical Academy of Sciences (PAS), February 3-4, 2005, which occurred at the specific request of His Holiness Pope John Paul II. Pope John Paul II's message to the participants was very clear: "Each human being, in fact, is alive precisely in so far as he or she is *'corpore et anima unus'* (body and soul united), and he or she remains so for as long as this substantial unity-in-totality subsists." This book must be read by every physician, priest, minister, emergency medical personnel, every parent and every teenager before any consideration of organ transplantation. Contact Life Guardian Foundation to obtain book.

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INSTRUCTIONS TO DOCUMENT HEALTH CARE REPRESENTATIVE SERVING AS AGENT FOR DEPENDENT PERSON WHO IS A

Minor or Mentally Incapacitated Person

Circle the one description that best describes the dependent person (minor or mentally incapacitated person).
Print full name of minor or mentally incapacitated person.
Print full name of primary health care representative serving as agent.
Primary health care representative serving as agent must sign and date this Directions to Protect and Preserve Life.
Indicate relationship: parent, legal guardian, or Durable Power of Attorney for Health Care (DPAHC).
Fill in phone numbers for primary health care representative serving as agent.
Print full name of secondary health care representative serving as agent.
Fill in phone numbers for secondary health care representative serving as agent.
Two witnesses must observe the primary and secondary health care representative serving as agent sign and date this document.
Neither witness may be related to this dependent person or have a claim on this dependent person's estate.
Neither witness may be a health care provider serving this dependent person at this time.
Both witnesses must sign and date.
Print name of care provider (organization or individual).
Provide (organization or individual): address, city, state, zip code and phone number of care provider.

These Directions to Protect and Preserve Life must be kept wherever medical treatment and care will be given. Have several copies to give to doctor, hospital, nursing home, assisted living facility or the like. Also provide these Directions to Protect and Preserve Life for the primary and secondary decision-makers and close relatives. After completion of this document it is recommended that copies be given to family members so that these Directions to Protect and Preserve Life will be immediately available to prevent delay in treatment and care.

We recommend that you review this with your attorney. We are not attorneys.

We recommend that these Directions to Protect and Preserve Life be notarized.

I, _____, do solemnly swear that in my presence the foregoing document was signed by _____, on this _____ day of _____, 20__ under penalty of perjury. I state that this document is page two of two.

SUBSCRIBED AND SWORN to before me (Should be sealed here)
this _____day of _____, 20__.

_____
(signature of Notary Public) My commission expires [expiry date].

(These are instructions to complete Directions to Protect and Preserve Life on page 2 of 2)

* * * * *

DIRECTIONS TO PROTECT AND PRESERVE LIFE BY HEALTH CARE REPRESENTATIVE SERVING AS AGENT FOR DEPENDENT PERSON WHO IS A

Minor or Mentally Incapacitated Person

These Directions to Protect and Preserve Life must be held by caregivers and the Primary and Secondary Health Care Representatives Serving as Agent, as authorized, **AT ALL TIMES** on behalf of this Dependent Person.

_____,
Dependent Person (print full name)

In the event of a medical emergency and/or admission to hospital, nursing home, assisted living facility, or the like, the said authorized primary and/or secondary health care representative serving as agent, designated as indicated, must be contacted.

I (we) wish for this Dependent Person to live the lifespan given by God. On behalf of this Dependent Person, I (we) direct that all medical and surgical treatments and care, including nutrition and hydration however administered, be given to protect and preserve the life of this Dependent Person. **Do not hasten death. Do not shorten life. Do not do an apnea test. Do not take any organ for transplantation or any other purpose.**

I, _____,
Primary Health Care Representative Serving as Agent (print full name)

am the designated primary health care representative serving as agent for the above named dependent person, as authorized and indicated below, to direct medical and surgical treatments and care as above **AT ALL TIMES.**

_____ _____
Signature of Primary Health Care Representative Serving as Agent Date

(Check One) ❑ Parent ❑ Legal Guardian ❑ DPAHC (Durable Power of Attorney for Health Care)

Home: (___)_____-_____ Office: (___)_____-_____ Cell: (___)_____-_____

The secondary designated health care representative serving as agent for the above named dependent in the event of my absence is:

_____
Name of Secondary Health Care Representative Serving as Agent (print full name)

_____ _____
Signature of Secondary Health Care Representative Serving as Agent Date

Home: (___)_____-_____ Office: (___)_____-_____ Cell: (___)_____-_____

_____ _____
Signature of Witness Date

_____ _____
Signature of Witness Date

Dependent resides at the following locaton:

Name of Care Provider (organization or individual) _____

Address _____

City: _____ State: _____ Zip code: _____

Home: (___)_____-_____ Office: (___)_____-_____ Cell: (___)_____-_____

* * * * *

Cut here along line

INSTRUCTIONS TO DOCUMENT HEALTH CARE REPRESENTATIVE SERVING AS AGENT FOR DEPENDENT PERSON WHO IS A

Minor or Mentally Incapacitated Person

Circle the one description that best describes the dependent person (minor or mentally incapacitated person).
Print full name of minor or mentally incapacitated person.
Print full name of primary health care representative serving as agent.
Primary health care representative serving as agent must sign and date this Directions to Protect and Preserve Life.
Indicate relationship: parent, legal guardian, or Durable Power of Attorney for Health Care (DPAHC).
Fill in phone numbers for primary health care representative serving as agent.
Print full name of secondary health care representative serving as agent.
Fill in phone numbers for secondary health care representative serving as agent.
Two witnesses must observe the primary and secondary health care representative serving as agent sign and date this document.
Neither witness may be related to this dependent person or have a claim on this dependent person's estate.
Neither witness may be a health care provider serving this dependent person at this time.
Both witnesses must sign and date.
Print name of care provider (organization or individual).
Provide (organization or individual): address, city, state, zip code and phone number of care provider.

These Directions to Protect and Preserve Life must be kept wherever medical treatment and care will be given. Have several copies to give to doctor, hospital, nursing home, assisted living facility or the like. Also provide these Directions to Protect and Preserve Life for the primary and secondary decision-makers and close relatives. After completion of this document it is recommended that copies be given to family members so that these Directions to Protect and Preserve Life will be immediately available to prevent delay in treatment and care.

We recommend that you review this with your attorney. We are not attorneys.

We recommend that these Directions to Protect and Preserve Life be notarized.

I, _____, do solemnly swear that in my presence the foregoing document was signed by _____, on this _____ day of _____, 20__ under penalty of perjury. I state that this document is page two of two.

SUBSCRIBED AND SWORN to before me (Should be sealed here)

this _____day of _____, 20__.

_____
(signature of Notary Public) My commission expires [expiry date].

* * * * *

DIRECTIONS TO PROTECT AND PRESERVE LIFE

Carry this card with you **AT ALL TIMES.** If I am unconscious, seriously ill, injured or unable to communicate and/or at admission to the hospital contact: ❑ Minister ❑ Priest ❑ Rabbi

_____

Name of Preferred Minister, Priest, or Rabbi

_____

Address, City, State, Zip Code and Telephone Number

I, _____,
(print your full name on blank line)

wish to live the lifespan given by God. I direct that all medical and surgical treatments and care, including nutrition and hydration however administered, be given to protect and preserve my life. **Do not hasten death. Do not shorten life. Do not do an apnea test. Do not take any organ for transplantation or any other purpose.**

_____ _____
Signature of Principal (or legal guardian if under 18) Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Witness Date

We recommend that these Directions to Protect and Preserve Life be notarized.

I, _____, do solemnly swear that in my presence the foregoing document was signed by _____ _, on this _____ day of _____, 20__ under penalty of perjury. I state that this document is page two of two.

SUBSCRIBED AND SWORN to before me this _____day of _____, 20__. (Should be sealed here)

_____
(signature of Notary Public) My commission expires [expiry date].

* * * * *

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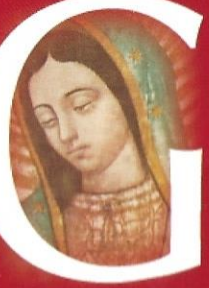

Life Guardian FOUNDATION

To protect and preserve God-given life from conception until true death

Educational Resources for Life

The Life Guardian Foundation offers a variety of educational resources in an effort to protect and preserve all human life from conception until true death. We encourage you to share this critical information with family, friends, colleagues, priests, ministers and youth. This knowledge gained is invaluable; it is a matter of life and death.

Speaking Engagements

Paul A. Byrne, M.D., President of Life Guardian Foundation, travels throughout the world delivering his presentations. His wealth of knowledge and expertise is unsurpassed. Large or small, all groups and organizations benefit from Dr. Byrne's sound instruction.

Schedule Dr. Byrne to deliver his life-saving message at your next event!
PAB@lifeguardianfoundation.org

Your Support is Appreciated

We depend on the generosity of individuals like you who believe that the work of Life Guardian Foundation is worthy. Contributions make possible the printing and distribution of all our educational resources, our website and speaking engagements. We strive to uphold the mission of the Life Guardian Foundation; to educate the public that life of the human person is a gift. Respect is owed to every human person regardless of their state of health throughout their entire lifespan from conception until his or her true death.

Please partner with us today for life!

WWW.LIFEGUARDIANFOUNDATION.ORG