

# Durable Power of Attorney For Health and Health Care Directives and Statement of Desires

## Protective Medical Decisions Document

for

**Ronald Lee Tichacek©™**

c/o 1400 Colorado Street; Boulder City, Nevada (89005) not D.C.

The creator of this document is an American State National, a Living Man standing upon the land and soil jurisdiction of these United States, must be honored and accorded their sovereign rights, in full, and plenty, must be delivered unto them without duress or distinction according to their wishes.

This is a Health Care Directive and must be followed as outlined below. Any violations of the following will be considered acts of unlawful trespass and such actions will be reported to the approximate authorities. As the person(s) responsible for this establishment, you personally will be at risk for fines and imprisonment upon conviction of criminal activity. This is an actual constructive lawful notice. I, solemnly make AFFIRM that the following statements are true and correct to the best of my knowledge.

**NOTICE TO AGENT IS NOTICE TO PRINCIPAL – NOTICE TO PRINCIPAL IS NOTICE TO AGENT  
NO TRESPASS**

THIS IS AN IMPORTANT LAWFUL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

### 1. DESIGNATION AND APPOINTMENT OF HEALTH CARE AGENT

I, **Ronald Lee Tichacek©™**, Agent of Record for **RONALD LEE**; an American State National, and living soul; do hereby designate and appoint:

**MACHEL LEE TICHACEK-BROWER**

(daughter)

1000 "B" Street

Palmyra, Nebraska 68418

402-430-6754

machel\_brower@hotmail.com

as my Attorney-In-Fact (herein called Agent) to make health care and personal decisions for me, as authorized in this document; if I become incapable to make such decisions on my own unless I state otherwise in this document.

**2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE**

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

This directive will also be in effect should I need medical care for an emergency or elective procedure to ensure that my wishes are executed for the care of my flesh and blood made in the image of God born on the land and soil of **Nebraska** State or adopter of **Nevada** State.

I, retain all my unalienable and infeasible God given rights, including sole possession and sole use of all my biological material, functions, and systems which are granted to me by my Creator.

I, retain my rights which **do not** come from "written instruments" or "hospital protocol" or municipal corporations which were created by men/women with rights equal to theirs but never greater. Any party claiming otherwise **must** support their claim with an affidavit and be prepared to testify under oath and under penalty of perjury.

None of the following persons may act as the Agent for the principal: Any of the principal's physicians, the physician's 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.

**3. DESIGNATION OF ALTERNATE AGENT**

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

**ALTERNATE AGENT #1**

**ALTERNATE AGENT #2**

Agent Name: Damon Brower

Agent Name: Patsy Burgess

Agent Address: 1000 B St., Palmyra, NE 68418

Agent Address: 1306 Palmwood, Boulder City, NV

Agent Phone: 402-430-1941

Agent Phone: 702-271-7972

**4. 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.

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**5. LIMITATIONS FOR DECISION MAKING AND AUTHORITY GRANTED TO MY AGENT**

- (1) If I am in a coma which doctors have reasonably concluded is irreversible, I desire that life prolonging treatments **NOT** be used.
- (2) If I have an incurable or terminal condition or illness and no reasonable hope of long term recovery or survival, I desire that life-sustaining or prolonged treatments **NOT** be used.
- (3) **I DO NOT** desire treatment to be provided or continued, if the burdens of the treatment outweighs the expected benefits. My Agent is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.
- (4) **DO NOT VENTILATE!**
- (5) **DO NOT RESUSCITATE!**
- (6) **DO NOT TUBE FEED!** See Statement of Desires "D"
- (7) **DO NOT USE INVASIVE MONITORING** such as intravenous lines and catheters.
- (8) **DO NOT USE ELECTRICAL DEVICES** such as a pacemaker.
- (9) **DO NOT USE CHEMOTHERAPY** such as drug treatment or radiation.
- (10) **DO NOT USE KIDNEY DIALYSIS**
- (11) **I DO NOT** authorized or consent to any COVID-19 test, COVID-19 vaccines, COVID-19 procedures or any biologics whatsoever that is listed as EUA – Emergency Use Only.
- (12) **I DO NOT** authorize or consent the use of the drug Remdesivir or any experimental drug, therapy or procedure.
- (13) **I DO NOT** authorize or consent to any psychological evaluations based on my decisions.

**5:1 AUTHORIZATION OF APPROVED TREATMENT**

- (1) **I DO** authorize the use of Ivermectin, Hydroxychloroquine and Vitamin C, D and Zinc infusions.
- (2) **I DO** authorize the use of Oxygen Therapy.
- (3) **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.
- (4) **I DO** authorize any and all welfare checks performed by my Agent.

## 5.1 AUTHORIZATION OF APPROVED TREATMENT Continued:

Upon the presence of any of the following symptoms that may be labeled as "Covid": Breathing Problems, Low Oxygen Levels, Cough, or Pneumonia. It is my wish the my Agent authorize the administration of the **Protocol developed by Dr. Vladimir Zelenko OR Frontline Doctors to include in part as needed and as symptoms present.**

### PROTOCOL:

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

Vitamin C: 1000mg, 1 time a day for 7 days

Vitamin D3: 10,000iu, once a day for 7 days or 50,000 iu once a day for 1-2 days

Azithromycin: 500mg, 1 time a day for 5 days

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 a 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

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

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

Blood thinners (i.e. Aspirin, Lovenox, Eliquis, Xarpto, Pradaxa

IV fluids and Oxygen

**My Agent may acquire this product from outside sources based on my need since hospitals rarely provide:** Functional Formularies, Liquid Hope Organic Tube Feeding Formula and Meal Replacement.

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

## 6. STATEMENT OF DESIRES

- (A) It is my desire to live in my home as long as it is safe and my medical needs can be met. My agent may arrange for a natural person, employee of an agency or provider of community-based services to come into my home to provide care for me. When it is no longer safe for me to live in my home, I authorize my agent to place me in a facility or home that can provide any medical assistance and support in my daily living that I require. Before being placed in such a facility or home, I wish for my agent to discuss and share information concerning the placement with me.
- (B) I desire that my life be prolonged to the greatest extent possible, without regards to my condition, the long term survival, or the cost of procedures.
- (C) I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My Agent is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.
- (D) Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. It is my desire to receive or continue receiving artificial nutrition and hydration by way of gastro-intestinal tract after all other treatment is withheld.

**6. STATEMENT OF DESIRES Contined:**

- (E) I desire that medical treatment to alleviate pain to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.
- (F) I desire that if my temperature is above normal, I want a cool moist cloth put on my head.
- (G) I desire that my mouth and lips be kept moist.
- (H) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.
- (I) I desire to be kept fresh and clean at all times. I wish to have warm baths often or warm showers if I am stable enough for a shower.
- (J) I desire that my personal care such as nail clipping, hair cutting, teeth brushing and shaving be done on a routine basis as long as they do not cause me pain.
- (K) I desire that my clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.
- (L) I desire you please arrange for me to watch television and/or listen to a radio when possible with my favorite programs or music.
- (M) I desire that I can enjoy the outdoors as often as possible by letting me spend time in appropriate outdoor places, even if it causes slight discomfort to either you or me.
- (N) Please maintain a cheerful atmosphere around me.

**7. STATEMENT OF INTERMENT, CREMATION AND WISHES**

I direct upon my death, my body be disposed of according to my wishes as follows:

- (A) Upon my death, my body is to be cremated, as contracted with the BOULDER CITY FAMILY MORTUARY in Boulder City, Nevada. If I should die, other than in Nevada; see contract for a Funeral Home Alternative.
- (B) One half of my ashes will be buried on my family plot at the Linwood Hill Cemetery in Linwood, Nebraska as on file with the Linwood National Board of Directors. (See attached map and letters)
- (C) The other half of my ashes will be disposed of by the planting of a tree or perennial flowering bush (recommend the Peony, if bush) at your choice of location; using my ashes as fertilizer, as a LIVING MEMORIAL.
- (D) The Granite Grave Marker, provided by the Veteran's Administration will be placed at my reserved family plot, below my mother's grave and to the right of my brother's grave. (See attached map and instruction diagram).

7. **STATEMENT OF INTERMENT, CREMATION AND WISHES Continued:**

(E) I wish no elaborate ceremony.

(F) I wish that the song: OVER THE RAINBOW by the artist: EVA CASSIDY; be played at both of my ceremonial burials. (CD's are among my personal possessions)

(G) Any decision, not already made, by circumstances that I cannot foresee, I entrust to my daughter or acting Agent..

8. **AUTOPSY, DISPOSTION 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. I **DO NOT** consent to any organ donations.

9. **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.

10. **REVOCAION 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.

11. **NO LIABILITY FOR UNKNOWN REVOCATIONS 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(s) or inaction(s), 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 which may hereby be in utter violation of my wishes and demands. Furthermore, in accordance with the letter of well-established law that all those acting contrary to my demands and stipulations and in violation of trust shall provide remedy. You are hereby given notice of yourself 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.

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I voluntarily sign this Durable Power of Attorney for Health Care Directives 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 effects that I grant my Agent. I am not under any duress and am of sound mind to make this lawful declaration.

Signed on this 27th day of April, 2022.

By: RLELW <sup>©™</sup>, Principal  
Ronald Lee Tichacek <sup>©™</sup>  
American State National  
All Rights Reserved – Without Prejudice

Address: 1400 Colorado Street; Suite C

City, State, Zip Boulder City, Nevada (89005) not D.C.

Date of Birth October 26, 1948

**WITNESSES**

I declare the **Ronald Lee Tichacek** <sup>©™</sup>, who signed or acknowledged this document (the principal) has identified 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.

**Witnesses no way transfers the issue of this document from its original jurisdiction on the land and soil; and creates no change in the origin of this document.**

**Witness # 1**

Signature Randall S Klein  
Printed Name Randall S. Klein  
Address 8440 Las Vegas Blvd South A-308<sup>apt</sup>  
City, State, Zip Las Vegas, NV 89123  
Phone No. 702-286-4722  
Date 04-27-2022

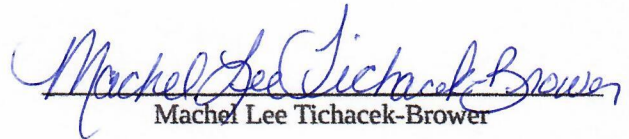
**Witness #2**

Signature Patsy B  
Printed Name Patsy Burgess  
Address 1306 Palmwood  
City, State, Zip Boulder City, NV 89005  
Phone No. 702 271-7972  
Date 27 Apr 2022

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**ACCEPTENCE OF APPOINTMENT**  
as  
**ATTORNEY IN FACT (AGENT)**  
**FOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE DIRECTIVE**  
and  
**STATEMENT OF DESIRES**  
for  
**Ronald Lee Tichacek©™, Principal**  
c/o 1400 Colorado Street; Suite C; Boulder City, Nevada (89005) not D.C.

I, the undersigned, **Machel Lee Tichacek-Brower**, agrees to act as Attorney-In-Fact (Agent) for **Ronald Lee Tichacek©™**, (Principal) pursuant to the provisions of this Durable Power of Attorney for Health Care Decisions and Statement of Desires.

  
Machel Lee Tichacek-Brower

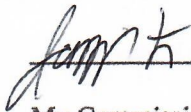
Nebraska State

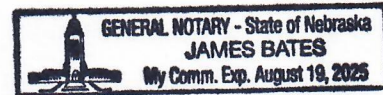
Lincoln County

On the 09 day of April, 2022, before me, a Notary Public within and for said County,

personally appeared **Machel Lee Tichacek-Brower**, to me known to be the person described as Attorney-In-Fact, (Agent) in and for who executed the forgoing instrument and acknowledged that he/she executed the same as his/her free act and deed for the purpose expressed in it.

(Seal)

  
\_\_\_\_\_  
Notary;  
My Commission expires on: 08/19/25



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NOTARY STATEMENT

State of Nevada

County of Clark

I swear on this 28<sup>th</sup> day of April, 2022; before me, a Notary Public within and for said

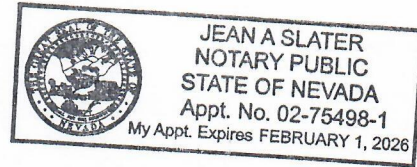
county, the above-named principal, **Ronald Lee Tichacek**™, personally appeared before me, of his/her own free will and of sound mind, signed and executed this Durable Power of Attorney for Health Care.

WITNESS my hand and official seal.

(Seal)

*Jean A Slater*  
Notary Public Signature

My Commission expires on: 02/01/2022



Recording Secretary and International Notarial Witness

I, a Recording Secretary and International Notarial Witness approved by the Nevada Assembly, was visited today by the living man, known to me as **Ronald Lee Tichacek**™, did affirm and sign this Durable Power of Attorney for Health Care, in my presence, stated, on this 28<sup>th</sup> day of April, 2022.

by: *Philip Schmidt* ©™, Recording Secretary  
All Rights Reserved  
*Without Prejudice*



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