URGENT MEDICAL INSTRUCTIONS

1•800•367•2228 or 1•480•922•9013

This card belongs to a whole body anatomical donor. Alcor Life Extension Foundation is authorized to take possession of the donation under the Uniform Anatomical Gift Act. It is imperative for medical research that the following instructions be immediately initiated. Please read carefully.

If the donor is unconscious or seriously injured, call for medical assistance and report the donor condition to the Alcor Medical Director. If the donor has been clinically deceased for less than one hour, report the donor condition to the Alcor Medical Director and begin the protocol listed below immediately upon pronouncement.

- Start IV and intubate with endotrachial tube
- Maintain cardiopulmonary resuscitation (CPR)
- Ensure pulse is present during compressions
- Begin ventilation via endotrachial tube
- Administer the following medication to minimize acidosis and inhibit clot formation:

MED EX CALL 24 HRS

TOLL-FREE 800-367-2222

COLLECT 460-922-9073

IN CASE OF DEATH FOLLOW

THIS BIOSTASIS PROTOCOL

PATIENT A-_____

CALL NOW FOR INSTRUCTIONS

PUSH 50,000 U. HEPARIN BY I.V.

AND DO CPR

WHILE COOLING WITH ICE TO 10 C.

KEEP PH TO 7.5

NO EMBALMING

NO AUTOPSY

This body belongs to a whole body anatomical donor. Alcor Life Extension Foundation is authorized to take possession of the donation under the Uniform Anatomical Gift Act. It is imperative for medical research that the following instructions be immediately initiated. Please read carefully.

If the donor is unconscious or seriously injured, call for medical assistance and report the donor condition to the Alcor Medical Director (1-800-367-2228 toll-free or 1-480-922-9013 collect). Immediately begin the protocol below upon pronouncement of death.

- Start IV and intubate with endotrachial tube
- Maintain cardiopulmonary resuscitation (CPR)
- Ensure pulse is present during compressions
- Begin ventilation via endotrachial tube
- Administer the following medication to minimize acidosis and inhibit clot formation:
  - 50,000U Heparin via IV
- Administer the following medications to reduce ischemic injury:

- 250,000U Streptokinase or equivalent Throbolitic
- 160mg Gentamycin Sulfate

- Continue CPR for a minimum of 15 minutes to circulate medications
- Perform extended CPR unless doing so is not possible or inappropriate because the donor has been deceased for more than one hour
- Pack the donor in ice (especially head, throat, axilla and groin) and/or place a cooling blanket at 2 to 4 degrees Centigrade
- Do not allow the donor to freeze at 0 degrees Centigrade (32 degrees Fahrenheit)

DO NOT AUTOPSY OR EMBALM!

It is imperative to this anatomical preservation that Alcor be contacted prior to any required autopsy and that only a limited autopsy be performed

URGENT MEDICAL INSTRUCTIONS
1-800-367-2228 or 1-480-922-9013

I, (name), of (Address , City , State, Zip), BEING OF SOUND MIND DECLARE THE FOLLOWING TO BE MY MEDICAL DIRECTIVE AND LIVING WILL:

WHEREAS, I believe that my most important attribute consists of my memories, and that the preservation of my neurophysiological essence is of utmost importance; and

WHEREAS, that our knowledge of medicine has witnessed an astonishing growth in the past several centuries, and that any physical condition from which I may suffer, will at sometime in the future be curable and/or repairable; and

WHEREAS, I am not afraid of so-called "future shock" and believe that I have the personal temperament and desire to survive in any future society or culture; and

WHEREAS, I believe that the experimental procedure of cryogenic preservation (hereinafter referred to as "Cryopreservation") offers the possibility, which I recognize as speculative, of eventual restoration of my human remains, but most importantly, my neurophysiological essence, to life and health; and

WHEREAS, I desire that my human remains, including at a minimum my brain and brain stem, be preserved by Cryopreservation; and

WHEREAS, I have executed separate instruments, entitled "Last Will and Testament," "Consent to Cryopreservation," "Authorization of Anatomical Donation," and "Cryopreservation Agreement," whereby I have arranged for and directed that upon my legal death my human remains be delivered for the experimental procedure of Cryopreservation to (Alcor, C.I., or Suspended Animation), a (state) Corporation with principal offices in (Address , City , State, Zip), including any agent of said organization; and

WHEREAS, I believe that the timeliness and thoroughness of the experimental procedure of Cryopreservation and the possibility of my human remains being restored to life and health will be enhanced if damage to or deterioration of my tissues, especially my brain and brain stem, from disease, pre-mortem ischemia, post-mortem ischemia, and autopsy is avoided or minimized up to the time that the cryogenic preservation of my human remains can begin; and

WHEREAS, I desire that whenever my life expectancy is limited, the primary purposes of any health care decision be to avoid or minimize damage to or deterioration of my tissues, especially my brain and brain stem, from disease, pre-mortem ischemia, post-mortem ischemia, and autopsy up to the time that the cryogenic preservation of my human remains can begin, and otherwise to enable timeliness and thoroughness in the ensuing procedure of cryogenic preservation of my human remains; and

WHEREAS, I desire to appoint and empower an Agent to make health care decisions on my behalf whenever I have been determined to be incapable of making an informed decision about providing, withholding, or withdrawing medical treatment.

NOW THEREFORE, I, (name _____), of (Address _____, City _____, State, Zip), willfully and voluntarily make known my desires and do hereby declare:

1. Primary Purposes of Health Care Decisions on My Behalf When My Life Expectancy Is Limited. I direct that the primary purposes of any health care decision, as defined in paragraph 6.c. of this advance directive, that is made on my behalf when my life expectancy is limited, as defined in paragraph 6.g. of this advance directive, be as follows:

a. To avoid or minimize damage to and deterioration of my tissues, especially my brain and brain stem, from disease, pre-mortem ischemia, post-mortem ischemia, and autopsy up to the time that the cryogenic preservation of my human remains can begin, as defined in paragraph 6.h. of this advance directive.

b. Otherwise to enable timeliness and thoroughness in the ensuing procedure of cryogenic preservation of my human remains.

I so direct in full knowledge that a health care decision made before the time that the cryogenic preservation of my human remains can begin may be different from a health care decision made at the time that the cryogenic preservation of my human remains can begin. Furthermore, I so direct even though the medical treatment, as defined in paragraph 6.e. of this advance directive, that results from such health care decision may not be medically necessary or may inadvertently hasten my death.

2. Health Care Providers.

a. Direction to Cooperate. I direct that my attending physician, other medical authorities responsible for my medical care, and their agents comply with this advance directive, cooperate (including cooperating in preparations for the cryogenic preservation of my human remains) with (Alcor, C.I., or Suspended Animation) and any agent of (Alcor, C.I., Suspended Animation), as defined in paragraph 6.a. of this advance directive, and, whenever I have been determined to be incapable of making an informed decision, as defined in paragraph 6.d. of this advance directive, about providing, withdrawing, or withholding medical treatment, adhere to the health care decisions made on my behalf by my Agent, named hereinafter.

b. Authorization of Medical Treatments.

1. I authorize my health care providers, when my life expectancy is limited, to provide medical treatment(s) as appropriate to avoid or minimize damage to and deterioration of my tissues, especially my brain and brain stem, from disease, pre-mortem ischemia, post-mortem ischemia, and autopsy up to the time that the cryogenic preservation of my human remains can begin, and otherwise to enable timeliness and thoroughness in the ensuing procedure of cryogenic preservation of my human remains.

I so authorize in full knowledge that the cryogenic preservation of my human remains may be inconsistent with traditional medical practice and its efficacy is speculative.

2. I direct that medical treatment be provided if deemed necessary to give me comfort care or to alleviate pain, unless such provision conflicts with the primary purposes of health care decisions as specified in paragraph 1 of this advance directive.

c. Attending Physician. I direct that (name _____), M.D., of (Address _____, City _____, State, Zip), serve as my attending physician if he or she is available and is willing and able to so serve. If (name _____) is not available or is unwilling or unable to so serve, I direct that a physician who is willing to comply with this advance directive within the limits of his or her authority serve as my attending physician.

d. Determination That I Am Incapable of Making an Informed Decision about Providing, Withholding, or Withdrawing Medical Treatment. Any determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me, shall take effect immediately, shall be communicated promptly to my Agent orally or in writing, shall be certified in writing promptly and every 180 days thereafter, and shall be in effect until withdrawn by my attending physician or the second physician or licensed clinical psychologist. However, if my death is imminent, as defined in paragraph 6.f. of this advance directive, and such determination has not been made heretofore, and for so long as a second physician or licensed clinical psychologist is not available, then such determination may be made solely by my attending physician. Neither a determination under this paragraph, nor a failure to make, communicate, or certify such determination, shall modify my express directions in this advance directive.

e. Release from Liability; Indemnification. No person who relies in good faith upon any representations by my Agent or, in the absence of instructions from my Agent, in good faith provides, withholds, or withdraws medical treatment for the purpose of carrying out or attempting to carry out my instructions in this advance directive, shall be liable to me, my estate, my heirs or assigns for recognizing my Agent's authority or for carrying out such instructions. I hereby agree to indemnify such person against any and all costs and expenses incurred as a result of recognizing my Agent's authority or as a result of carrying out or attempting to carry out such instruction, except to the extent that either (Alcor, C.I., or Suspended Animation) is responsible for such costs and expenses pursuant to the Cryopreservation Agreement executed between me and (the Foundation, or that another third party is responsible for such costs and expenses, and except that funds passing to (Alcor, C.I.,or Suspended Animation) from my estate or as a consequence of any contract entered into by me shall not be used to pay such costs and expenses.

3. Agent. As further specified below, I appoint and empower an Agent, named hereinafter, to make health care decisions on my behalf whenever I have been determined to be incapable of making an informed decision about providing, withholding, or withdrawing medical treatment.

a. Naming of Agent. I hereby appoint (name _____), of (Address _____, City _____, State, Zip), to serve as my Agent. I direct that no surety be required of my Agent as such.

b. Grant of Powers to Agent. I hereby grant to my Agent, named above, full power and authority to make health care decisions on my behalf as described in this advance directive whenever I have been determined in accordance with paragraph 2.d. of this advance directive to be incapable of making an informed decision about providing, withholding, or withdrawing medical treatment. My Agent's authority hereunder is

effective so long as I am incapable of making an informed decision. The powers of my Agent shall include the following:

1. To request, consent to, refuse, or withdraw consent to any type of medical treatment on my behalf. This authorization specifically includes the power to request or consent to the administration of dosages of pain-relieving medication in excess of standard dosage in an amount sufficient to relieve pain, even if such medication carries the risk of addiction or may inadvertently hasten my death.

2. To request, receive, and review any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to or refuse the disclosure of this information.

3. To employ and discharge my health care providers.

4. To direct or authorize my admission to, discharge from, or transfer to or from any nursing home, adult home, hospital, other medical care facility, my place of residence, any other private residence, any other facility offering hospice, nursing, or long term care services, a facility for the cryogenic preservation of human remains, or any other place, even against medical advice.

5. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to health care providers, the signing of any documents on my behalf related to my medical treatment or the refusal or withdrawing thereof, and contracting on my behalf for any health care related service or facility.

c. Instructions to Agent. I direct that my Agent, in making any health care decision whenever I have been determined to be incapable of making an informed decision about providing, withholding, or withdrawing medical treatment, take into consideration my medical diagnosis and prognosis and the likely damage to and deterioration of my tissues, especially my brain and brain stem, from disease, pre-mortem ischemia, post-mortem ischemia, and autopsy with and without the treatment, together with any information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with medical treatment or non-treatment. My Agent shall not authorize a course of treatment that he knows, or upon reasonable inquiry ought to know, is inconsistent with the principal purposes specified in paragraph 1 of this advance directive. If my Agent cannot determine what treatment choice I would have made on my own behalf, then my Agent shall make a choice for me based upon what he believes to be in my best interests, consistent with such purposes.

d. Reimbursement; Waiver of Liability; Indemnification. My Agent shall not be entitled to compensation for services performed under this advance directive, but he shall be entitled to reimbursement for all reasonable costs and expenses incurred as a result of carrying out or attempting to carry out any provisions of this advance directive. My agent shall not be liable to me, my estate, my heirs or assigns for any costs and expenses of treatment or non-treatment pursuant to his authorization, based solely on that authorization, and I hereby agree to indemnify my Agent against any and all such costs and expenses, except to the extent that either (Alcor, C.I., or Suspended Animation) is responsible for such costs and expenses, pursuant to the Cryopreservation Agreement executed between me and (Alcor, C.I., or Suspended Animation), or that another third party is responsible for such costs and expenses, and except that funds passing to

(Alcor, C.I., or Suspended Animation) from my estate or as a consequence of any contract entered into by me shall not be used to pay such costs and expenses.

4. Specific Instructions For When My Death Is Imminent.

a. I direct that (Alcor, C.I. or Suspended Animation), and (name _____), of (Address _____, City _____, State, Zip), be notified immediately of my medical condition.

b. I direct that, up to the time that the cryogenic preservation of my human remains can begin, I be kept alive or resuscitated or my resuscitation continue to be attempted, and that my death not be pronounced. Such efforts should be undertaken if necessary through the application of artificial life-prolonging procedures, as defined in paragraph 6.b. of this advance directive.

c. I direct that, once the time that the cryogenic preservation of my human remains can begin is reached, I be permitted to die. Specifically, I direct that any artificial life-prolonging procedures be withheld or be withdrawn promptly and that my legal death be declared promptly upon cessation of vital functions. In the absence of my ability to give directions regarding the use of artificial life-prolonging procedures, it is my intention that this advance directive be honored by my family and attending physician as the final expression of my legal right to refuse medical treatment and accept the consequences of such refusal.

5. Miscellaneous Provisions.

a. This advance directive shall not terminate in the event of my disability.

b. I revoke any prior advance medical directive.

c. This advance directive is intended to be valid in any jurisdiction in which it is presented.

d. The provisions of, and powers delegated under, this advance directive are separable, so that the invalidity of one or more provisions or powers shall not affect any others.

6. Definitions.

a. The term "agent of the _____ Foundation" means an agent, representative, contractor, employee, volunteer, assistant, associate, physician, or other person authorized to act on behalf of (Alcor, C.I.,or Suspended Animation).

b. The term "artificial life-prolonging procedure" means a mechanical or other procedure that artificially replaces, enhances, or assists a failing or failed vital function, and may include, but is not necessarily limited to, artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation.

c. The term "health care decision" means any decision about providing, withholding, or withdrawing medical treatment, selecting health care providers, or selecting the place of medical treatment.

d. The term "incapable of making an informed decision" means unable to understand the nature, extent and probable consequences of a proposed health care decision or unable to make a rational evaluation of the risks and benefits of a proposed health care decision as compared with the risks and benefits of alternatives to that decision, or unable to communicate such understanding in any way.

e. The term "medical treatment" means any type of medical care, treatment, surgical procedure, diagnostic procedure, other medical procedure, oral or intravenous medication (including, but not necessarily limited to, anti-coagulants, thrombolytic agents, and/or anti-acids), and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial lowering of body temperature and artificial life-prolonging procedures.

f. The term "my death is imminent" means that failure of a vital function or functions is imminent, or such failure has taken place and I am being kept alive with artificial life-prolonging procedures.

g. The term "my life expectancy is limited" means that I am in a chronic vegetative state, or my condition is terminal and my attending physician has determined that no medical treatment can afford recovery from such condition, even though the provision of an artificial life-prolonging procedure or procedures could protract the dying process.

h. The term "the time that the cryogenic preservation of my human remains can begin" means the time that both:

1. An agent of (Alcor, C.I., or Suspended Animation) is available and states that he or she is prepared to initiate cryogenic preservation of my human remains; and

2. A person authorized to pronounce my legal death is available and prepared to do so.

By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

Dated this _____ day of _____, 200__.

_____
Name

Address:

_____

_____

The declarant signed the foregoing advance directive in my presence.
I am not the spouse or a blood relative of the declarant.

Signed:

_____

Witness

Name:

_____

Address:

_____

_____

Signed:

_____

Witness
Name:

_____

Address:

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Signed:

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Witness
Name:

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Address:

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