Karen Johnson Davidson County
Batch# 1070171 DEEDQC
11/13/2023 09:08:10 AM 17 pgs
Fees: $87.00 Taxes: $0.00
20231113-0087876

THIS INSTRUMENT PREPARED BY:
Martin Heller Potempa & Sheppard
2122 21st Avenue South
Nashville, Tennessee 37212
(615) 800-7096

This Deed was prepared based on information provided by the parties and no independent title examination was prepared.

STATE OF California
COUNTY OF Los A

The actual consideration for this transfer is: $10.00

LEIF SCHEICK, AFFIANT

Subscribed and sworn to before me, this 1 day of November 2023.

see attached CA jurat
NOTARY PUBLIC

My Commission Expires: 10/9/26

QUITCLAIM DEED

Address New Owner:	**Send Tax Bills To:**	**Tax Information:**
LEIF SCHEICK and XANIA PAYNE, CO-TRUSTEES 614 Skyview Drive Nashville, TN 37206	New Owner	Map and Parcel No.: 083 10 0 352.00

FOR AND IN CONSIDERATION of Ten and No/100ths Dollars ($10.00) and other good and valuable consideration, the receipt of all of which is hereby acknowledged, I, Sandra Halleck Scheick, ("Grantor") do hereby quitclaim, transfer and convey unto Leif Scheick and Xania Payne, Co-Trustees of the Sandra Halleck Scheick Revocable Trust, created November 1, 2023, its successors and assigns, all of my right, title and interest in certain real property in the County of Davidson, State of Tennessee, identified below.

This is improved property known as 614 Skyview Drive, Nashville, Tennessee 37206, and more particularly described as follows:

Land in Davidson County, Tennessee, being Lot No. 38 on the Plan of Rolling Acres Subdivision, of record in Book 1130, page 34, said Register's Office, to which plan reference is hereby made for a more complete description.

CALIFORNIA JURAT WITH AFFIANT STATEMENT GOVERNMENT CODE § 8202

☑ See Attached Document (Notary to cross out lines 1–6 below)
☐ See Statement Below (Lines 1–6 to be completed only by document signer[s], not Notary)

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Signature of Document Signer No. 1 *Signature of Document Signer No. 2 (if any)*

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

County of Los Angeles

Subscribed and sworn to (or affirmed) before me

on this 1 day of November, 2023,
by *Date* *Month* *Year*

(1) Leif Scheick

(and (2) _____),
Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

A. LUSBY
Notary Public - California
Los Angeles County
Commission # 2416155
My Comm. Expires Oct 9, 2026

Place Notary Seal and/or Stamp Above

Signature _____
Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: Quitclaim Deed

Document Date: 11/1/23 Number of Pages: 1

Signer(s) Other Than Named Above: _____

©2017 National Notary Association

Being the same property conveyed to Sandra Halleck Scheick, an unmarried person, from O. C. Carroll and wife, Alberta Milom Carroll, by Warranty Deed recorded in the Register's Office of said county and state at Book 5339, Page 144-145.

Whenever used, the singular shall include the plural, the plural the singular, and the use of any gender shall be applicable to all genders.

This conveyance is subject to any and all existing easements and restrictions as shown of record.

This quitclaim deed was prepared based upon information provided by the parties and no independent title examination was prepared in preparation of this deed.

IN WITNESS WHEREOF, Grantor has executed this instrument on this the 1 day of November 2023.

Leif Scheick, as Power of Attorney
for Sandra Halleck Scheick, Grantor

Xania Payne, as Power of Attorney
for Sandra Halleck Scheick, Grantor

STATE OF California)

COUNTY OF Los Angeles)

Personally appeared before me, the undersigned Notary Public, in and for the said county and state, the within named **Leif Scheick, as Power of Attorney for Sandra Halleck Scheick**, the Grantor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who acknowledged that he executed the within instrument for the purposes therein contained.

Witness my hand and official seal at office, this 1 day of November 2023.

see attached CA acknowledgment

Notary Public A. Lusby

My Commission Expires: 10/9/26

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT **CIVIL CODE § 1189**

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)
County of Los Angeles)

On 11/1/23 before me, A. Lusby, Notary Public,
Date *Here Insert Name and Title of the Officer*

personally appeared Leif Schenck
Name(s) of Signer(s)

,

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 California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

A. LUSBY
Notary Public - California
Los Angeles County
Commission # 2416155
My Comm. Expires Oct 9, 2026

Signature _____
Signature of Notary Public

Place Notary Seal Above

OPTIONAL

Though this section is optional, completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document
Title or Type of Document: Quitclaim Deed Document Date: 11/1/23
Number of Pages: 2 Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____	Signer's Name: _____
☐ Corporate Officer — Title(s): _____	☐ Corporate Officer — Title(s): _____
☐ Partner — ☐ Limited ☐ General	☐ Partner — ☐ Limited ☐ General
☐ Individual ☐ Attorney in Fact	☐ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian or Conservator	☐ Trustee ☐ Guardian or Conservator
☐ Other: _____	☐ Other: _____
Signer Is Representing: _____	Signer Is Representing: _____

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Being the same property conveyed to Sandra Halleck Scheick, an unmarried person, from O. C. Carroll and wife, Alberta Milom Carroll, by Warranty Deed recorded in the Register's Office of said county and state at Book 5339, Page 144-145.

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This conveyance is subject to any and all existing easements and restrictions as shown of record.

This quitclaim deed was prepared based upon information provided by the parties and no independent title examination was prepared in preparation of this deed.

IN WITNESS WHEREOF, Grantor has executed this instrument on this the 1st day of November 2023.

Leif Scheick, as Power of Attorney
for Sandra Halleck Scheick, Grantor

Xania Payne, as Power of Attorney
for Sandra Halleck Scheick, Grantor

STATE OF _____)

COUNTY OF _____)

Personally appeared before me, the undersigned Notary Public, in and for the said county and state, the within named **Leif Scheick, as Power of Attorney for Sandra Halleck Scheick**, the Grantor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who acknowledged that he executed the within instrument for the purposes therein contained.

Witness my hand and official seal at office, this ____ day of November 2023.

Notary Public

My Commission Expires: _____

STATE OF Michigan)

COUNTY OF Jackson)

Personally appeared before me, the undersigned Notary Public, in and for the said county and state, the within named **Xania Payne, as Power of Attorney for Sandra Halleck Scheick**, the Grantor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who acknowledged that she executed the within instrument for the purposes therein contained.

Witness my hand and official seal at office, this 1st day of November 2023.

Notary Public

My Commission Expires: 01/11/2029

Jackson

LINDSEY LEONARD
NOTARY PUBLIC - STATE OF MICHIGAN
COUNTY OF JACKSON
My Commission Expires January 11, 2029
Acting in the County of Jackson

"Exhibit A"

SANDRA HALLECK SCHEICK
ADVANCED CARE PLAN,
DURABLE POWER OF ATTORNEY FOR HEALTH CARE
AND
LIVING WILL

ARTICLE I. Title. This Instrument shall be entitled and known as the SANDRA HALLECK SCHEICK ADVANCED CARE PLAN, DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL, and is being entered into this 19th day of May 2021.

I, SANDRA HALLECK SCHEICK, of Davidson County, Tennessee, do hereby appoint my children, XANIA PAYNE and LEIF SCHEICK, jointly or the survivor of them, as my lawful attorney-in-fact (hereinafter referred to as "my attorney") for me and in my stead, to make all health care decisions for me and on my behalf as I might do for myself if able, in accordance with the provisions of Tennessee Code Annotated §§ 34-6-201 et seq., as they are now constituted and as they may later be amended.

This Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will shall not be affected by the passage of time or by my subsequent disability or incapacity. All acts done by my attorney pursuant to this power during any period of my disability or incapacity shall have the same effect and enure to the benefit of and bind me and my successors in interest as if I were competent and not disabled.

Furthermore, if through any judicial proceeding I am deemed to be incapacitated and a conservator of my person is to be appointed, I desire that my attorney be appointed as such conservator of my person.

ARTICLE II. Definitions. As used in this Instrument unless the context otherwise requires:

(1) This "Instrument" means this Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will.

(2) "Durable power of attorney for health care" means a durable power of attorney to the extent that it authorizes an attorney-in-fact to make health care decisions for the principal.

(3) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition and includes medical care as that term is defined in Tennessee Code Annotated § 32-11-103(5).

(4) "Health care decision" means consent, refusal of consent, or withdrawal of consent to health care.

(5) "Health care institution" means health care institution as defined in Tennessee Code Annotated § 68-11-1602.

(6) "Health care provider" means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or practice of a profession.

(7) "Person" includes an individual, corporation, partnership, association, the state, a city, county, city and county, or other public entity or governmental subdivision or agency, or any other legal entity.

(8) "Act" refers to Public Acts of 1990, Chapter No. 831, as codified under Tennessee Code Annotated § 34-6-201, entitled "An Act to Amend Tennessee Code Annotated, Title 34, Chapter 6, Relative to Durable Power of Attorney for Health Care", as amended through the date hereof.

(9) "Terminal condition" means any disease, illness, injury, or condition, including but not limited to a coma or persistent vegetative state, sustained by any human being, from which there is no reasonable medical expectation of recovery and which, as a medical probability, will result in the death of such human being, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life processes.

(10) All other definitions as may later be added to Tennessee Code Annotated § 34-6-201, as it now exists or may later be amended, are hereby incorporated by reference.

ARTICLE III. Powers. The powers of my attorney shall include the following:

1. My said attorney shall have the power to make health care decisions in my behalf before or after my death, to the same extent as I could make health care decisions for myself had I the capacity to do so, including but not limited to:

(a) making a disposition under the "Uniform Anatomical Gift Act", Tennessee Code Annotated, Title 68, Chapter 30;

(b) authorizing an autopsy pursuant to the "Post Mortem Examination Act", Tennessee Code Annotated, Title 38, Chapter 7; and

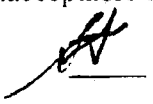
(c) directing the disposition of remains pursuant to Tennessee Code Annotated, Title 68, Chapter 4.

2. My said attorney shall have full authority to make health care decisions in my behalf in the event I have a terminal condition. The decision to withhold or withdraw health care may be made by my attorney permitting me to die naturally with only the administration of palliative care as defined in Tennessee Code Annotated § 32-11-103(7). My attorney is further authorized to withhold or withdraw artificially provided food, water or other nourishment or fluids only if I have so indicated by checking the appropriate line in Article V.

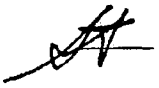
3. My said attorney shall have full authority to make all other health care decisions in my behalf in the event I am incapacitated or disabled, to the extent allowed by law.

4. I specifically include the provisions of the Tennessee Living Will statute, Tennessee Code Annotated §§ 32-11-101 et seq., and which are hereby incorporated by reference as a part of this Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will. This instrument shall be construed and interpreted as both a durable power of attorney for health care and as a living will. The inclusion of living will provisions within this instrument, and the enumeration of any other specific items, rights or powers herein shall not limit or restrict my said attorney, and shall not be construed or interpreted as limiting or restricting the general powers herein granted to my said attorney to make all necessary decisions concerning health care. Nevertheless, should the durable health care power of attorney provisions of this instrument not be enforceable for any reason, or if my said attorney should be unavailable or unable to act for any reason, I direct that the living will provisions set forth below shall stand alone to express my wishes, it being my intention that this declaration shall then be honored by my family and physician as the final expression of my legal right to refuse medical care and accept the consequences of such refusal:

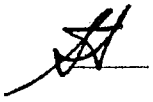
ARTICLE IV. Quality of Life. I want my doctors and my attorney to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions:



Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.



Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.



Dependent in all Activities of Daily Life: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.



End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples include widespread cancer that does not respond anymore to treatment: chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

ARTICLE V. Treatment. If my quality of life becomes unacceptable to me and my condition is irreversible, I direct that medically appropriate treatment be provided, or not be provided as follows:

☐ Yes ☒ No **CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

☐ Yes ☒ No **Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.

☐ Yes ☒ No **Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

☐ Yes ☒ No **Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

I, SANDRA HALLECK SCHEICK, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstance set forth below, and do hereby declare:

> If at any time I should have a terminal condition and my attending physician has determined that there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life, or the life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

ARTIFICIALLY PROVIDED NOURISHMENT AND FLUIDS: By checking the appropriate line below, I specifically:

☒ authorize the withholding or withdrawal of artificially provided food, water, or other nourishment or fluids after no less than eight (8) days of observation, treatment and care.

____ DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other nourishment or fluids.

ORGAN DONOR CERTIFICATION: Notwithstanding my previous declaration relative to the withholding or withdrawal of life- prolonging procedures, if as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead according to Tennessee Code Annotated § 68-3-501(b), to maintain me on artificial support systems only for the period of time required to maintain the viability of and to remove such organs and/or tissues. By checking the appropriate line below, I specifically:

 desire to donate my organs and/or tissues for transplantation.

_____ desire to donate my _____
_____
_____.

_____ DO NOT desire to donate my organs or tissues for transplantation.

In the absence of my ability to give directions regarding my medical care, it is my intention that this declaration shall be honored by my family and physicians as the final expression of my legal right to refuse medical care and accept the consequences of such refusal. The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated § 32-11-103. I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

ARTICLE VI. Right to Information. My said attorney shall have the same right as I would have to receive information regarding the proposed health care, to receive and review medical records, and to consent to the disclosure of medical records. As such, I authorize the disclosure to my attorney-in-fact hereunder by all health care providers and all "covered entities" as that term is defined under the Privacy Regulations (the "Privacy Regulations"), promulgated under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), of all of my personal health information (including, but not limited to "protected health information," as that term is defined under the Privacy Regulations), in order to afford my Agent the broadest access to my personal health information and financial information, without limitation.

ARTICLE VII. Revocation.

(a) After executing this Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will, I may revoke the appointment of my attorney by any of the following methods:

(1) By notifying my attorney orally or in writing; or

(2) By revoking the authority granted to my attorney to make health care decisions by notifying the health care provider orally or in writing.

(b) If I notify the health care provider orally or in writing that the authority granted to my attorney to make health care decisions is revoked, the health care provider shall make the notification a part of my medical records and shall make a reasonable effort to notify my attorney of the revocation.

(c) This Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will revokes any prior durable power of attorney for health care previously executed by me.

(d) If authority granted by this Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will is revoked under this Article, a person is not subject to criminal prosecution or civil liability for acting in good faith reliance upon such durable power of attorney unless the person has actual knowledge of the revocation.

ARTICLE VIII. Emergency Treatment. This Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will does not affect the law governing health care treatment in an emergency.

ARTICLE IX. My Objection Overrules. Nothing in this Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will authorizes my attorney to consent to the withholding or withdrawal of health care necessary to keep me alive, if I object to the withholding or withdrawal of the health care. In such instance, that health care decision shall be governed by the law that would apply if there were no durable power of attorney for health care or living will; however, with respect to other and subsequent health care decisions, this Advanced Care Plan, Durable Power of Attorney for Health Care and Living Will shall remain in effect unless expressly revoked as provided in Article VII hereof or in the Act.

ARTICLE X. Warning Statement to Principal. (I understand this statement is a requirement of the Act.)

"This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document.

You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (1) authorizes anything that is illegal or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you."

ARTICLE XI. Exoneration for Actions of Good Faith. I further absolve and hold harmless from blame, in respect to any act or decision made by my attorney hereunder, and in respect to any attending physician(s) who offers his (or their) opinion in this regard, all of my said attorney, attending physician(s) and all personnel who act upon their instructions in regard to my health care treatment or to any other procedure authorized by this Instrument, so long as such attorney, physician(s) and/or other personnel act(s) merely in good faith.

ARTICLE XII. Severability. If any one or more of the provisions contained in this instrument shall for any reason be held invalid, illegal or unenforceable for any reason, such invalidity, illegality or unenforceability shall not affect any other provisions of this Instrument (including, without limitation, the living will provision standing alone), which shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein. It is my intention that if any provision of this instrument is capable of two constructions, one of which would render the provision void and the other of which would render the provision valid, then the provision shall have the meaning which renders it valid.

IN WITNESS WHEREOF, I have executed this Instrument, entitled the SANDRA HALLECK SCHEICK ADVANCED CARE PLAN, DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL, on the date first indicated above, for the purposes herein contained, and state that I have read and understand all of the provisions contained herein.

Jennyl Morgan
Witness

Sandra Halleck Scheick
SANDRA HALLECK SCHEICK, Principal

Shelly Sabra
Witness

THE SANDRA HALLECK SCHEICK ADVANCED CARE PLAN. DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND LIVING WILL

Dated: May 19. 2021

AFFIDAVIT OF WITNESSES

I declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to me to be the principal; that the principal signed this instrument in my presence; that the principal appears to be of sound mind, fully aware of the action taken herein and its possible consequence, and under no duress, fraud, or undue influence; that I am not the person appointed as attorney in fact by this document; that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the principal by blood, marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon her death; and, that, 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 or codicil thereto now existing, or by operation of law.

Jenny Morgan
Witness

Date: May 19, 2021

I declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to me to be the principal; that the principal signed this instrument in my presence; that the principal appears to be of sound mind, fully aware of the action taken herein and its possible consequence, and under no duress, fraud, or undue influence; that I am not the person appointed as attorney in fact by this document; that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the principal by blood, marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon her death; and, that, 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 or codicil thereto now existing, or by operation of law.

Shelly Sara
Witness

Date: May 19, 2021

STATE OF TENNESSEE)
COUNTY OF DAVIDSON)

Subscribed, sworn to and acknowledged before me by SANDRA HALLECK SCHEICK, the declarant, and subscribed and sworn to before me by Jenny Morgan and Shelly Salva, witnesses, this 19th day of May 2021.

Lindsay Norfleet
Notary Public

My commission expires:

03/06/2024

LINDSAY NORFLEET
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY

AFFIDAVIT
OF
MENTAL INCAPACITY

STATE OF TENNESSEE
COUNTY OF Williamson

The undersigned, Sasha Bowers, MD, a resident of Nashville, Davidson County, having been duly sworn, depose and say as follows:

The undersigned is the attending physician of SANDRA HALLECK SCHEICK (the "Patient"). The undersigned has examined the Patient and found the Patient to be incapacitated and/or disabled so that the Patient is unable to administer his or her own affairs on a regular basis. The undersigned does make and sign this affidavit this 25th day of OCTOBER 2023

(print name) Sasha Bowers, MD

SUBSCRIBED AND SWORN TO before me this 25th day of OCTOBER 2023.

Notary Public

My commission expires:

10/24/2026

ALMA HERNANDEZ
STATE OF TENNESSEE NOTARY PUBLIC
WILLIAMSON COUNTY