

IN THE DISTRICT COURT OF THE FIFTH JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF TWIN FALLS

IN RE THE GENERAL ADJUDICATION
OF RIGHTS TO THE USE OF WATER FROM
THE COEUR D'ALENE-SPOKANE RIVER
BASIN WATER SYSTEM

CIVIL CASE NUMBER: 49576

Ident. Number 95-14355Date Received: 5/5/10Receipt No: NO24239Received By: Ken

NOTICE OF CLAIM TO A WATER RIGHT

ACQUIRED UNDER STATE LAW

For Domestic and/or Stockwater Purposes

Where Daily Use is less than 13,000 gallons per day

1. Name of Claimant(s) William H and Patricia D Swann Family Trust Phone (208) 664-1764Mailing Address P.O. Box 953 CDA ID Zip 83814
Street or Box City State2. Date of Priority: (Only one per claim) 12/1/1963
Month/Day/Year (YYYY)3. Source of water supply (Check one) Ground Water () or Other () (a) CDA Lake
which is tributary to (b) Spokane River4. Location of Point of Diversion is: Township 49N, Range 4W, Section 9,
SW 1/4 of SE 1/4, or Govt. Lot 3 BM. County of _____;Parcel (PIN) no. 0-5000-00E-014-A

Additional points of diversion if any: _____

If available, GPS coordinates: _____

5. Description of diverting works (Wells, Pumps, Spring boxes, Pipelines, Etc.) including the dates of any changes or enlargements in use, the dimensions of the diversion works as constructed and as enlarged and the depth of each well.

3/4 Hp Submersible pump set on lake bed in pvc intake pipe, 1" poly pipe from pump to cabin.

6. Water is claimed for the following: (limited to Domestic and/or Stockwater uses. See page 1 of the instructions.)

For Domestic purposes from 1/1 to 12/31 amount 0.04 cfs (X) or AFY ()

For _____ purposes from _____ to _____ amount _____

7. Total Quantity claimed 0.04 cfs (X) or AFY ()

8. Non-irrigation uses. Describe fully. (eg. Domestic: give number of households served if single ownership;

Stockwater and Number of livestock) 1 home

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9. Location of Place of Use is: Township 49N, Range 4W, Section 9,
SW 1/4 of SE 1/4, Govt. Lot 3 BM. Parcel (PIN) no. 0-5000-00E-014-A
If different than shown in Item 4

for (Check One) **Domestic** (X) **Stock** () **Domestic and Stock** ()

Additional places of use, if any NA

10. In which county (ies) are lands listed above as place of use located? Kootenai

11. Do you own the property listed above as place of use? Yes (X) No ()

If the answer is No, describe in Remarks below the authority you have to claim this water right.

12. Describe any other water rights used at the same place and for the same purposes as described above.

_____ or None (X)

13. Remarks:

14. Basis of Claim (Check One) Beneficial Use (X) Posted Notice () License () Permit () Decree ()

Court _____ Decree Date _____ Plaintiff v. Defendant _____

If applicable provide IDWR Water Right Number _____

15. Signature(s)

(a.) By signing below, I/We acknowledge that I/We have received, read and understand the form entitled "How you will receive notices in the Coeur d'Alene-Spokane River Basin Adjudication." (b.) I/We do () do not () wish to receive and pay a small annual fee for monthly copies of the docket sheet.

Number of attachments: one

For Individuals: I/We do solemnly swear or affirm under penalty of perjury that the statements contained in the foregoing document are true and correct.

Signature of Claimant (s) _____ Date: _____

_____ Date: _____

For Organizations: I do solemnly swear or affirm under penalty of perjury that I am

✓ Trustee of William H. and Patricia D. Swann Family Trust
Title Organization

that I have signed the foregoing document in the space below as

✓ Trustee of William H. and Patricia D. Swann Family Trust
Title Organization

and that the statements contained in the foregoing document are true and correct.

Signature of Authorized Agent Patricia D. Swann Trustee Date 4-28-10

Title and Organization Trustee of William H. and Patricia D. Swann Family Trust

16. Notice of Appearance:

Notice is hereby given that I, _____, will be acting as attorney at law of behalf of the claimant signing above, and that all notices required by law to be mailed by the director to the claimant signing above should be mailed to me at the address listed below.

Signature _____

Address _____

Date _____

Last Name _____ Identification No. _____

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49N04W9SWSE

LOT 3

POU

POD

SCANNED
DATE 3/28/20

3. I understand the full importance of this Directive and am mentally competent to make this Directive.

No participant in the making of this directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

A DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. **DESIGNATION OF HEALTH CARE AGENT.** 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. If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive.

Name of Health Care Agent: PATRICIA D. SWANN

Address of Health Care Agent: P.O. Box 953
Coeur d'Alene, ID 83814

Telephone Number of Health Care Agent: (208) 664-1764

For the purposes of this Directive, "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 portion of this directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

3. **GENERAL STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this directive, including as set forth in paragraph immediately above, I hereby

3. **LIVING WILL AND DURABLE POWER OF ATTORNEY
FOR HEALTH CARE FOR WILLIAM H. SWANN**

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. **Designation of Health Care Agent.** I, WILLIAM H. SWANN, of Kootenai County, Idaho, do hereby designate and appoint my wife, PATRICIA D. SWANN, of Kootenai County, Idaho, as my attorney in fact and agent (hereafter referred to as "Agent") to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decisions" 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 my 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-prolonged care, treatment, services, and procedures.

4. **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 my organs for medical purposes.

5. **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:

BILL SWANN

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