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BOOK 219 PAGE 905

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Please Print or Type Information.

Document Title(s) or transactions contained therein:

1. Durable POWER OF ATTORNEY FOR
2. HEALTH CARE DECISION AND NOMINATION
3. OF ~~THE~~ GUARDIAN
- 4.

GRANTOR(S) (Last name, first, then first name and initials)

1. SCHMID, LITA C
- 2.
- 3.
- 4.

☐ Additional Names on Page _____ of Document.

GRANTEE(S) (Last name, first, then first name and initials)

1. DRUSHEL, MICHELLE
2. DEETER, DAWN
- 3.
- 4.

☐ Additional Names on Page _____ of Document.

LEGAL DESCRIPTION (Abbreviated: i.e., Lot, Block, Plat or Section Township, Range, Quarter/Quarter)

☐ Complete Legal on Page _____ of Document.

REFERENCE NUMBER(S) Of Document assigned or released:

☐ Additional Numbers on Page _____ of Document.

ASSESSOR'S PROPERTY TAX PARCEL/ACCOUNT NUMBER

☐ Property Tax parcel ID is not yet assigned.☐ Additional Parcel Numbers on Page _____ of Document.

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**DURABLE POWER OF ATTORNEY
FOR
HEALTH CARE DECISIONS AND NOMINATION OF GUARDIAN**

ARTICLE 1. IDENTIFICATION AND APPOINTMENT

1.1 **Designation.** I, **RTTA C. SCHMID**, domiciled and residing at Stevenson, Washington, designate **MICHELE DRUSHEL**, if living, able, and willing to serve, as my attorney-in-fact ("Agent") to exercise the powers set forth below. ("Agent") to exercise the powers set forth below Agent is not one of my physicians, an employee of one of my physicians, or an owner, administrator or employee of the health care facility where I reside or receive care.

1.2 **Intention of Principal.** By this instrument I intend to create a Durable Power of Attorney for Health Care Decisions, authorized by RCW 7.70.065 and 11.94.

1.3 **Immediately Effective; Durability.** The powers granted to Agent in this document shall be effective immediately and shall not be affected by any subsequent disability that I may suffer.

1.4 **Wishes Regarding Care to Prevail.** I desire that my wishes as expressed in this instrument be carried out through the authority given to Agent despite any contrary feelings, beliefs, or opinions of members of my family, my friends, my guardian, or health care providers.

ARTICLE 2. GENERAL MEDICAL POWERS

2. **General Medical Powers.** I authorize Agent to exercise the powers granted relating to matters involving my health and medical care. In exercising such powers, I direct Agent first to try to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner, however rudimentary. If I am unable to give an informed consent to a proposed medical treatment, Agent shall give, withhold, or withdraw such consent for me based upon any treatment choices that I have expressed to Agent while not disabled, whether under this instrument or otherwise. If Agent cannot determine the treatment choice that I would want made under such circumstances, then I direct Agent to make such choice for me based upon what Agent believes to be in my best interests. Accordingly, I authorize Agent as follows:

2.1 **Obtain Access to Medical Records and Other Personal Information.** I authorize Agent (a) to request, receive and review any information, verbal or written, regarding my personal affairs or my personal or mental health, including medical and hospital records; (b) to execute any releases or other documents that may be required in order to obtain such information; and (c) to disclose such information to such persons, organizations, firms or corporations as Agent deems appropriate.

2.2 **Employ and Discharge Health Care Personnel.** I authorize Agent to employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as Agent shall deem necessary for my physical, mental and emotional well-being, and to pay them (or to cause to be paid to them) reasonable compensation.

2.3 Give, Withhold or Withdraw Consent to Medical Treatment. I authorize Agent (a) to give or withhold consent to any medical procedure, test or treatment, including surgery; (b) to arrange for my hospitalization, convalescent care, hospice, or home care; (c) to summon paramedics or other emergency medical personnel and to seek emergency treatment for me, as Agent deems appropriate; and (d) under circumstances in which Agent determines that certain medical procedures, tests or treatments are no longer of benefit to me, or where the benefits are outweighed by the burdens imposed, to withdraw, revoke, modify or change consent to such procedures, tests, and treatments as well as hospitalization, convalescent care, hospice or home care which I or Agent may have previously allowed or consented to or which may have been provided due to emergency conditions. I direct Agent to be guided by (1) the provisions of this instrument; (2) any reliable evidence of preferences that I may have expressed on the subject, whether before or after the execution of this document; (3) what Agent thinks I would want done in the circumstances if I were able to express myself; [and] (4) any information given to Agent by the physicians treating me as to my medical diagnosis and prognosis, and the intrusiveness, pain, risks, and side effects associated with the treatment; and (5) my strong preference that I remain in my residence so long as practicable, although it may be substantially less convenient and more expensive for me to be cared for there than in a hospital, convalescent care facility, hospice or elsewhere.

2.4 Exercise and Protect My Rights. I authorize Agent to exercise my right to privacy and my right to make decisions regarding my medical treatment even though the exercise of my rights might hasten my death or be against conventional medical advice.

2.5 Authorize Relief From Pain. I authorize Agent to consent to and arrange for the administration of pain-relieving medication of any kind or for other surgical or medical procedures calculated to relieve my pain, including conventional pain-relief therapies which Agent thinks may be helpful, even though such medications or procedures may lead to permanent physical damage or addiction, or may hasten the moment of (but not intentionally cause) my death.

2.6 Grant Releases. I authorize Agent to grant releases from liability for damages suffered by me to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by Agent or who render written opinions to Agent in connection with any matter described in this instrument. I authorize Agent to sign documents titled or purporting to be "Refusal to Treatment" and "Leaving Hospital Against Medical Advice," as well as any necessary waivers of or release from liability required by a hospital or physician to implement my wishes regarding medical treatment or nontreatment.

ARTICLE 3. SPECIFIC POWERS REGARDING LIFE-SUSTAINING TREATMENT

3. Confirmation of Directive to Physicians. I confirm the terms of the Directive to Physicians that I executed on January 15, 2001 which records my wish that the application of life-sustaining procedures that would serve only to prolong artificially the moment of my death either not be utilized or be withdrawn. Insofar as the terms of this instrument are inconsistent with those of the Directive to Physicians, I wish the terms of this instrument to prevail.

3.1 **General Intentions.** I wish to live and enjoy life as long as possible. However, I do not wish to receive medical treatment that will only postpone the moment of my death from an incurable and terminal condition or prolong an irreversible coma. For this purpose (a) "terminal condition" means a condition that is reasonably expected to result in death within twelve months regardless of the treatment I receive, and (b) "irreversible coma" refers to a permanent loss of consciousness from which there is no reasonable possibility that I will return to a cognitive and sapient life, and shall include, but not be limited to, a persistent vegetative state.

3.2 **Specific Authorization.** If two licensed physicians who are familiar with my condition have diagnosed and noted in my medical records that:

(a) I am unable to give informed consent to medical treatment that is proposed or available for my condition and my condition is terminal as defined in 3.1 above, or

(b) I have been in a coma for at least sixty days and the coma is irreversible as defined in 3.1 above, Agent is authorized to:

(i) Direct that treatment or procedures which will only postpone the moment of my death or prolong an irreversible coma be withheld, or, if previously instituted, direct that they be withdrawn;

(ii) Direct that procedures, INITIAL ONE: _____ other than / _____ including, but not limited to, manual feeding used to provide me with nourishment and hydration (for example, all forms of intravenous and parenteral feeding and all forms of tube feeding and misting) be withheld, or, if previously instituted, direct that they be withdrawn;

(iii) Sign on my behalf any document necessary to carry out the powers granted in this article (including waivers or releases of liability required by any health care provider;

(iv) Direct and consent to the writing of a "No Code" or "Do Not Resuscitate" order by any health care provider, and direct the withholding of cardiopulmonary resuscitation or mechanical ventilation; and

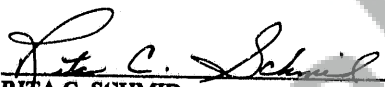
(v) Order whatever is appropriate to keep me as comfortable and as free of pain as is reasonably possible, including the administration of pain-relieving medication, surgical and medical procedures calculated to relieve my pain, and unconventional pain relief therapies which my Agent believes may be helpful, even though such medications or procedures may lead to permanent physical damage, addiction or hasten the moment of (but not intentionally cause) my death.

In exercising the powers given Agent under this Article 3, Agent shall follow the instruction of this document and any subsequent instructions, oral or written, that I may give Agent while I am competent. Notwithstanding such instructions, if Agent cannot determine the treatment choice I would want made under the circumstances, then Agent should make such choice for me after determining what Agent believes to be in my best interests.

CERTIFICATION

I certify that I have read the contents of this Article 3 directing or authorizing Agent to refuse medical treatment for me under the circumstances specified in this Article 3, that such provisions have been explained to me to my satisfaction, that I understand such provisions, and that such provisions state my wishes and desires under the circumstances described.

PRINCIPAL:


RITA C. SCHMID

ARTICLE 4. MISCELLANEOUS POWERS

4. Powers Relating to Care and Control of My Body. I authorize Agent as follows with respect to the care and control of my body:

4.1 Residence. I authorize Agent to make all necessary arrangements for me at any hospital, hospice, nursing home, convalescent home, or similar facility and to assure that provision is made for all of my needs. In this connection Agent should bear in mind my strong preference to remain in my residence so long as possible.

4.2 Companionship. I authorize Agent to provide for such companionship for me as will meet my needs and preferences at a time when I am disabled or otherwise unable to arrange for such companionship.

4.3 Funeral Arrangements. I authorize Agent to make such arrangements for my INITIAL ONE: funeral / cremation and burial / interment, including the purchase in advance of a plot or marker, and such other arrangements as Agent believes are in accordance with my wishes.

ARTICLE 5. THIRD-PARTY RELIANCE

5. Inducement. In order to induce others to act in accordance with the instructions of Agent as authorized in this document, I make the following directions:

5.1 Reliance on Agent's Authority and Representations. No person who relies in good faith upon the authority of Agent under this document shall incur any liability to me, my estate, or my heirs, successors or assigns. Furthermore, no person shall incur any liability who relies in good faith on any representation made by Agent regarding (a) the existence of Agent's powers; (b) the scope of Agent's powers; (c) my competency at the time this document is executed or later; or (d) any representation made by Agent that this document has not been revoked or that Agent continues to

serve as Agent.

5.2 **No Liability for Unknown Revocation or Amendment.** I direct that no person acting in good faith in reliance upon the instructions of Agent shall incur any liability to me, my estate, my heirs, successors or assigns as a result of any revocation or amendment of this document. In all such instances all persons shall be held harmless for any loss resulting from such good faith reliance.

5.3 **Right of Agent to Act Alone.** Agent may exercise all powers under this document alone. Agent's signature or act under the authority of this document may be accepted by all third persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts of my Agent shall inure to the benefit of and bind me, my estate, my heirs, successors and assigns.

5.4 **Release of Information.** All physicians and other health care personnel are authorized to release to Agent all information or photocopies of all records which my Agent may request. If I am incompetent at the time Agent shall request such information, all persons are authorized to treat any such request for information as the request of my legal representatives and to honor such requests on that basis. I hereby waive all privileges that may be applicable to such information and records and to any communication pertaining to me and made in the course of any confidential relationship recognized by law. Agent may disclose such information to such persons as Agent shall deem appropriate.

5.5 **Resort to Courts.** I authorize Agent to participate in court proceedings on my behalf regarding the scope and validity of this document and the acts of Agent, including the initiation or other participation in declaratory relief actions, actions for injunctions and actions for damages against persons who negligently or willfully fail or refuse to comply with instructions of Agent.

ARTICLE 6. MISCELLANEOUS PROVISIONS

6.1 **Reimbursement of Costs.** Agent shall be reimbursed for all reasonable costs and expenses incurred on my behalf under any provision of this document. I direct that this provision be interpreted liberally in favor of full and complete reimbursement.

6.2 **Authority to Execute Documents and Incur Costs.** Agent is authorized to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient or proper in order to exercise any of the powers described in this document and to incur reasonable expenses in the exercise of such powers.

6.3 **Nomination of Guardians.** If protective proceedings for my person or estate are ever commenced, I nominate Agent as guardian of my person and LORRAINE T. NIEDERT as guardian of my estate.

6.4 **Governing Law.** I direct that the internal laws of the State of Washington, without regard to choice or conflict of law principles, shall in all respects govern this document.

6.5 Revocation and Amendment. I reserve the right during my competency to revoke this document, to amend it in writing, and to substitute another person as Agent. Any amendment shall be attached to the original hereof. Agent shall have no authority to amend or revoke this document.

6.6 Successor. If for any reason MICHELE DRUSHEL declines, fails, resigns or for any reason cannot serve as my Agent hereunder, I hereby appoint DAWN DEXTER to be my attorney-in-fact ("Agent") hereunder, with all of the rights and powers of the original Agent and with full power of substitution in the premises.

6.7 Photocopies. My Agent is authorized to make photocopies of this document as frequently and in such quantity Agent deems appropriate. I direct that a photocopy be given the same force and effect as the original. I direct my Agent to see that a photocopy of this document is placed with my medical records.

6.8 Severability. If any provision of this Document is invalid or unenforceable under applicable law, this document shall be ineffective to the extent of such invalidity only, without affecting the remaining parts hereof.

6.9 Exculpation. I release and forever discharge Agent and Agent's estate, heirs, successors and assigns from all liability and from all claims or demands or all kinds arising out of acts or omissions of Agent, except for willful misconduct or gross negligence.

IN WITNESS WHEREOF, I have hereunto set my hand in the State of Washington the 14th of Dec., 2001.

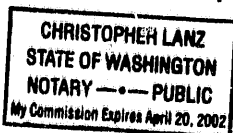
PRINCIPAL:

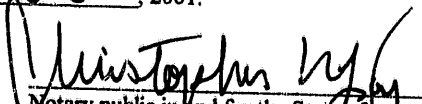

RITA C. SCHMID

STATE OF WASHINGTON)
) ss.
COUNTY OF SKAMANIA)

I certify that I know or have satisfactory evidence that RITA C. SCHMID is the person who appeared before me, and said person acknowledged that said person signed this instrument and acknowledged it to be said person's free and voluntary act for the uses and purposes mentioned in the instrument.

Dated this 14th day of December, 2001.




Notary public in and for the State of
Washington, residing at Lawson, WA

My appointment expires:

ACCEPTED AND AGREED TO:

Michele Druschel
MICHELE DRUSHEL

Dawn Dexter
DAWN DEXTER

Unofficial
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