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Page 1 of 13
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Filed by: DENNIS MOORE
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J. MICHAEL GARVISON
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Return Address:

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Camas, WA 98607

Document Title(s) or transactions contained herein: APPOINTMENT OF HEALTH CARE REPRESENTATIVE
GRANTOR(S) (Last name, first name, middle initial) MOORE RAYMOND S [ ] Additional names on page _____ of document.
GRANTEE(S) (Last name, first name, middle initial) MOORE DENNIS R [X] Additional names on page 3 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 Documents 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.
The Auditor/Recorder will rely on the information provided on the form. The Staff will not read the document to verify the accuracy or completeness of the indexing information.

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decision about your health care. Before signing consider these important facts:

Facts about Part B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannnot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

Facts about Part C (Giving Health Care Instructions)

You also have the right to give instructions for health care providerss to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts about Completing This Form

This form is valid only if you sign it volluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duraation of this advance directive, it will not expire. If you hve set an expiration date, and you become unable to direct you are able to make those decisions again.

You may revoke this document. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

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

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTH DATE and ADDRESS HERE:

Raymond Sowl Moore
Name

24 September 1915
Birth Date

101 Moore Falls Road

Washougal, WA
Address

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE

RSM My entire life

_____ Other period (_____years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint DENNIS R. MOORE as my health care representative.

My representative's address is 101 MOORE FALLS ROAD, MAGALIA, CA 95954

My representative's telephone number is ~~(503)585-1697~~. (530) 835-5111 or 5500

I appoint KATHLEEN MOORE KORDENBROCK my alternate health care representative.

My alternate's address is 7721 Sunset Way, Orangevale, California 95662

My alternate's telephone number is 916/987-7221 7221 Dm

I authorize my representative (or alternate) to direct my health care when I cannot do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. Limits

Special conditions or instructions:

Of deceased, cremation, No funeral

INITIAL IF THIS APPLIES

_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support

"Life Support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INTITIAL IF THIS APPLIES

RMM My representative MAY decide about life support for me. (If you do not initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding

One sort of life support is food and water supplied artificially by a medical device known as tube feeding.

INTITIAL IF THIS APPLIES

RMM My representative MAY decide about tube feeding for me. (If you do not initial this space, then your representative MAY NOT decide about tube feeding.)

18 February 2005
Date

SIGN HERE TO APPOINT A HEALTH CARE REPRESENATIVE

IVAN DASSENKO
RAYMOND MOORE RMM

2. Life Support

"Life Support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable. (i.e "heroic measures")

INTITIAL IF THIS APPLIES

RM My representative MAY decide about life support for me. (If you do not initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding

One sort of life support is food and water supplied artificially by a medical device known as tube feeding.

INTITIAL IF THIS APPLIES

RM My representative MAY decide about tube feeding for me. (If you do not initial this space, then your representative MAY NOT decide about tube feeding.)

18 Feb 05
Date

SIGN HERE TO APPOINT A HEALTH CARE REPRESENATIVE

RM Moore
~~IVAN DASSENKO~~
RAYMOND MOORE

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends," means that you want you physician to try life support and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in Part B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below.

1. **Close to Death.** If I am close to death and life support would only postpone the moment of my death;

A. INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

B. INTITIAL ONE:

_____ I want any other life support that may apply.

_____ I want tube feeding only as my physician recommends.

_____ want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again;

A. INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends,

_____ DO NOT WANT tube feeding.

B. INTITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and the illness is in an advanced stage, and I am consistently and permanently unable to communicate, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve;

A. INITIAL ONE:

_____ I want to receive tube feeding.

_____ I tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

4. **Extraordinary Suffering.** If life support would not help my medical condition and would make me suffer permanent and server pain;

A. INITIAL ONE:

_____ I want to receive tube feeding.

I want tube feeding only as my physician recommends.

I DO NOT WANT tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

I want NO life support.

5. General Instructions.

INITIAL IF THIS APPLIES:

I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctors and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. **Additional Conditions or Instructions.**

_____

_____

_____

(Insert description of what you want done.)

7. **Other Documents.** A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INTIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect.

_____ I have a health care power of attorney, and I REVOKE IT.

RM I DO NOT have a health care power of attorney.

18 Feb 2005
Date

SIGN HERE TO GIVE INSTRUCTIONS

~~IVAN DASSENKO~~ Raymond Moore

2-22-05 WITNESS

~~Stephanie Jackson~~ 2-22-05 WITNESS

PART D: DECLARATION OF WITNESSES

We declare that the person signing this Advance Directive:

a. Is personally known to us or has provided proof of identity.

b. Signed or acknowledged that person's signature on this Advance Directive in our presence.

c. Appears to be of sound mind and not under duress, fraud or undue influence.

d. Has not appointed either of us as health care representative or alternative representative; and

e. Is not a patient for whom either of us is attending physician.

Witnessed By:

Joyce Dutro 2-22-05 Joyce Dutro

Signature of Witness/Date Printed Name of Witness

Stephanie Jackson 2-22-05 Stephanie L. Jackson

Signature of Witness/Date Printed Name of Witness

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this Advance Directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

Part E: ACCEPTANCE BY HEALTH CARE REPRESENATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this Advance Directive or otherwise made known to me. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe is good faith to be that person's best interest.

Dennis Moore 3/31/05

Signature of Health Care Representative/Date

Dennis Raymond Moore

Printed Name

PEGGY B. LOWRY NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 02-23-07

Signature of Alternate Health Care Representative/Date

Printed Name

WASHINGTON SHORT-FORM INDIVIDUAL ACKNOWLEDGMENT RCW 42.44.100

State of Washington
County of Washington } ss.

I certify that I know or have satisfactory evidence that Dennis Raymond Moore
Name of Signer
is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated: 3/31/05
Month/Day/Year

Peggy B Lowry
Signature of Notary Public

Notary Public
Title (Such as "Notary Public")

My appointment expires:
2/23/07
Month/Day/Year of Appointment Expiration

PEGGY B. LOWRY NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 02-23-07

Place Notary Seal Above

OPTIONAL

Though the information in this section is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

RIGHT THUMBPRINT OF SIGNER

Description of Attached Document

Title or Type of Document: Appointment of Health Care Representative

Document Date: 2/18/05 Number of Pages: 11

Signer(s) Other Than Named Above: n/a