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Filed for record at the request of:
Linda A. Anderson
P.O Box 873
Washougal, WA 98671

DURABLE POWER OF ATTORNEY

I, Harvey Dale Erickson, resident of the State of Washington, revoke any powers of attorney I may have given in the past and give Linda Ann Anderson (referred to below as "the agent") a durable power of attorney. I intend that it not be limited by any disability I may have in the future.

1. POWERS

A. The agent shall act on my behalf and for my benefit, and shall have all powers over my estate that I have or acquire. These shall include, but not be limited to, the following: the power to make deposits to, and payments from, any account in my name in any financial institution; the power to open and remove items from any safe deposit box in my name; the power to sell, exchange or transfer title to stocks, bonds or other securities; the power to sell, convey or encumber any real or personal property.

B. The agent shall have the power to consent to, or to withhold consent from, medical treatment, shall have all powers necessary or desirable to provide for my support, maintenance, health and comfort; the agent shall be entitled to obtain and use any of my medical records or other individually identifiable health information to the same extent as I would myself. This is intended as a full release of all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. I authorize the agent to revoke any community property agreement and to transfer any property to my spouse or registered domestic partner as a gift. _____ (*Initial* here if revocation of a community property agreement and gifts to a spouse or registered domestic partner are authorized. If they are not authorized, cross out all of paragraph C.)

D. I authorize the agent to make gifts of my property to the following person or persons: N/A.
Gifts under this paragraph may be:
N/A in any amount
N/A not more than $ N/A per year

(If gifts are authorized under paragraph D, either *initial* next to "in any amount" or *initial* next to "no more than" and fill in a dollar amount. If gifts are not authorized, cross out all of paragraph D.)

No gift may be made under this power of attorney, except to a spouse or registered domestic partner if authorized under paragraph 1(C), unless authorized by this paragraph.

2. EFFECTIVE DATE, REVOCATION AND DISPOSITION OF REMAINS

A. This power of attorney shall become effective (initial the choice that applies):

HE immediately

_____only when my agent certifies in writing that I lack the mental capacity to make important decisions independently. (This certification may be made using the box at the end of this document, or may be made in a separate writing.)

B. It shall remain in effect until revoked or until my death.

C. After my death, my agent shall have the authority to act as my representative for purposes of controlling the disposition of my remains, as authorized under RCW 68.50.160, if I have not otherwise made lawful provision for their disposition.

D. I may revoke this power of attorney by giving written notice to the agent and, if the power of attorney has been recorded, by recording the written instrument of revocation in the county office where deeds are recorded.

E. If I give notice of revocation after my agent has certified that I lack the mental capacity to make important decisions, then my agent's power of attorney shall be suspended unless and until a court determines that the revocation was not effective.

3. RIGHTS AND DUTIES OF THE AGENT

A. My estate shall hold the agent harmless from, and indemnify the agent for, all liability for acts done for me in good faith based on this power of attorney.

B. The agent shall be required to account to any subsequently appointed personal representative.

4. NOMINATION OF GUARDIAN

I nominate the agent for consideration by the court as my guardian or limited guardian in the event that any guardianship proceeding for my person or estate should be commenced.

5. SUBSTITUTE AGENT

I appoint N/A to serve as substitute agent in place of the agent named in paragraph 1 above, if the agent named in paragraph 1 is unable or unwilling to serve. A statement signed by the substitute agent, affirming that the agent named in paragraph 1 is unable or unwilling to serve shall be sufficient to establish that the agent is unable or unwilling to serve.

(If no substitute agent is named, this paragraph should be crossed out.)

Dated: May 19th 2013

Harvey Dale Erickson

State of Washington County of Clark

On 5-19-13, a person I know to be Harvey Dale Erickson appeared before me in person, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned above.

Dated: May 19, 2013

Angela Arnett

Notary Public, State of Washington,
residing at: Vancouver, WA
Commission expires: 2-15-15

ANGELA ARNETT NOTARY PUBLIC COMMISSION EXPIRES 02-15-15 STATE OF WASHINGTON

Certification of Incapacity

I certify that the principal lacks the mental capacity to make important decisions independently.

dated: _____

_____
signature

printed name: _____

address: _____

_____

_____

telephone: _____

your SSI

Durable Power of Attorney for Health Care

This document has been reprinted with permission from the Washington State Medical Association. This form is not a substitute for the advice of an attorney. Any legal question you may have about a Durable Power of Attorney for Health Care should be directed to an attorney.

Notice to Person Executing This Document

This is an important legal document. Before executing this document you should know these facts:

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You can limit that right in this document if you choose.
- When exercising his or her authority to make health care decisions for you when deciding on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by including them in this document or by making them known in another manner.
- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

1. Creation of Durable Power of Attorney for Health Care

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by RCW 11.94.010. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions.

2. Designation of Health Care Agent and Alternate Agents

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I Harvey Erickson designate and appoint:

MILDRED M MEDLIN 13722 Washougal River Rd Washougal WA 98671 — 360-837-1308

(Name) (Address) (City) (State) (Zip) (Phone)

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care recognized in RCW 11.94.010 and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that Mildred Madden is unable or unwilling to serve, I grant these powers to Linda Anderson
(Name) *(Address)* *(City)* *(State)* *(Zip)* *(Phone)*

In the event that both Mildred Madden and Linda Anderson are unable or unwilling to serve, I grant these powers to N/A
(Name) *(Address)* *(City)* *(State)* *(Zip)* *(Phone)*

3. General Statement of Authority Granted.
My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in any Health Care Directive or other form of "living will" I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order:
(1) Therapy or other procedure given for the purpose of inducing convulsion;
(2) Surgery solely for the purpose of psychosurgery;
(3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW;
(4) Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.

4. Special Provisions

DATED this 5-19th day of May, 2013.

Harvey Erickson
GRANTOR

STATE OF WASHINGTON)
)ss.
COUNTY OF Clark)

I certify that I know or have satisfactory evidence that the GRANTOR, Harvey Erickson, signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

DATED this 19th day of May, 2013.

Angela Arnett

NOTARY PUBLIC in and for the State of Washington,
residing at Vancouver, WA
My commission expires 2-15-15

ANGELA ARNETT NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 02-15-15