AFN #2017002012 Recorded Sep 27, 2017 01:01 PM DocType: POA Filed by: PAUL J PEARCE Page: 1 of 8 File Fee: $80.00 Auditor Robert J. Waymire Skamania County, WA

WHEN RECORDED RETURN TO:

Paul J. Pearce

PO Box 307

Stevenson, WA 98648

DOCUMENT TITLE(S)

Durable Power of Attorney for Health Care for Paul J. Pearce

REFERENCE NUMBER(S) *of Documents assigned or released:*

[ ]Additional numbers on page_____of document.

GRANTOR(S):

Paul J. Pearce

[ ]Additional names on page _____ of document.

GRANTEE(S):

Kay Roeder

[ ]Additional names on eage_____of document.

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

[ ]Complete legal on page _____ of document.

TAX PARCEL NUMBER(S):

[ ]Additional parce numbers on page _____ of document.

The Auditor/Recorder will rely on the information provided on this form. The staff will not read the document to verify the accuracy or completeness of the indexing information.

Durable Power of Attorney for Health Care
for

Paul J. Pearce

1. My Agent. I, Paul J. Pearce, a resident of the State of Washington, appoint Kay Roeder, as my Agent with full authority to make health care decisions on my behalf. See Exhibit A for my Agent's contact information.

2. Alternate. If for any reason my Agent becomes unable or unwilling to act, I appoint Doug Slyter, as my Agent with full authority to make health care decisions on my behalf. See Exhibit A for my Alternate Agent's contact information

3. Durable Power of Attorney. This Power of Attorney shall not be affected by my disability and will remain in effect to the extent permitted by RCW 11.94 or until revoked.

4. Effective Date. This Power of Attorney shall become effective immediately.

5. Revoking My Power of Attorney. I may revoke this Power of Attorney by a written notice mailed or delivered to my Agent. See Exhibit C for Revocation Notice.

6. Powers of Agent. 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 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 sustaining care, treatment, services and procedures. The power and authority to make health care decisions shall include, but not be limited to, the following:

   6.1 Access to Medical Records. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information in my medical records which my Agent may request. With respect to my Agent only, I hereby waive all privileges attached to the physician patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent may designate.

6.2 HIPAA Release. In addition to the other powers granted by this document, I grant to my Agent the power and authority to serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended from time to time, and its regulations. My Agent will serve as my "HIPAA personal representative" and will exercise this authority at any time that my Agent is exercising authority under this document.

6.3 Health Care Providers. My Agent is authorized to employ and discharge health care providers, including physicians, psychiatrists, dentists, nurses and therapists, as my Agent shall deem appropriate for my physical, mental and emotional well-being.

6.4 Admission to Facilities. My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate. My Agent is not authorized to arrange for my commitment to or placement in a mental health treatment facility, except pursuant to RCW 71.05.

6.5 Consent to Procedures. My Agent is authorized to arrange for and consent to medical, therapeutic and surgical procedures for me, including the administration of drugs. My Agent is not authorized to arrange for or consent to electroconvulsive therapy. The power to make health care decisions for me shall include the power give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

6.6 Visitation. My Agent shall have the unfettered right to visit me at any hospital or other medical facility where I reside or receive treatment.

6.7 Reserved Rights. Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision.

6.8 Withdrawal of Life-Sustaining Procedures.

A. I have executed a Health Care Directive expressing my intentions with respect to the use, continuation, or withdrawal of life sustaining procedures; thus, I direct my Agent to take all appropriate steps to implement my directions.

7. Reimbursement of Costs. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this document.

8. Nomination of Guardian. I nominate my Agent as the guardian of my person or estate for consideration by the court if protective proceedings for my person or estate are hereafter commenced.

9. Accounting. My Agent shall keep accurate records of my financial affairs, including documentation of all transactions in which my Agent is involved. Upon request, my Agent shall be required to present such records to me, a successor Agent, a guardian of my estate or person, or to the acting personal representative or executor named in my Will.

10. Ratification and Indemnity. I hereby ratify all that my Agent shall lawfully do or cause to be done by virtue of this document, and I shall hold harmless and indemnify my Agent from all liability for acts done in good faith.

Paul Pearce
My Signature

9/14/17
Date

Notarization

State of Washington
County of Skamania

I certify that I know or have satisfactory evidence that Paul Pearce, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on 09/14/2017.

Jayne Borden
SIGNATURE OF NOTARY

JAYNE I. BORDEN
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
FEBRUARY 15, 2019

Jayne Borden
PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires 02/15/2019.

Health Care Directive
of

Paul J. Pearce

As a person with capacity, I willfully and voluntarily execute this Health Care Directive. In the absence of my ability to give directions regarding the use of life sustaining treatment, it is my intention that this directive shall be honored by my family and all medical providers as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences of such refusal. If I have appointed another person to make health care decisions for me, whether through a durable power of attorney or otherwise, then I request that my agent be guided by my desires as expressed in this directive or as otherwise communicated to my agent. It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

1. Withhold and Withdraw Treatment. If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, and where the application of life sustaining treatment would serve only artificially to prolong the process of my dying, I direct that the following treatment be withheld or withdrawn: (*initial the choices that apply*)

   NO Artificial nutrition.

   YES Artificial hydration.

   NO Artificial respiration.

   NO Cardiopulmonary Resuscitation (CPR) , including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure.

   NO Surgery to prolong my life or keep me alive.

   NO Blood dialysis or filtration for lost kidney function.

   NO Blood transfusion to replace lost or contaminated blood.

   NO Medication used to prolong life, not for controlling pain.

   NO Any other medical treatment used to prolong my life or keep me alive.

2. Comfort Care and Pain Medication. If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, I want treatment to relieve my pain and symptoms and make me comfortable if I appear to be in pain or experiencing other signs of discomfort, even if my physicians or other medical providers believe this might unintentionally hasten my death.

3. Health Care Institutions – Refusal to Honor My Advance Directive. If I am a patient at a health care institution whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs when this document comes into effect, I direct that my consent to admission shall not constitute implied consent to procedures or courses of treatment that conflict with this advance directive. Moreover, if a health care institution declines to follow my wishes set out in the advance directive when this document comes into effect, I direct that I be transferred as soon as possible to a hospital, nursing home, or other institution that will honor the instructions provided in this document.

4. Changes and Revocation. I understand that, before I sign this directive, I can add to or delete from or otherwise change the wording of this directive. I further understand that at any time I may revoke this directive entirely or execute a new directive with different provisions. Any changes must be consistent with Washington State law or federal constitutional law to be legally valid.

5. Additional Directions: I make the following additional directions regarding my care:

   A. Anti-Anxiety drugs. I do not wish the use of anti-anxiety drugs if they cause loss of perception or consciousness.

I have signed this document in the presence of two witnesses.

Paul Pearce — 9/14/17

My Signature — Date

Statement of Witnesses

On 9/14/17, the maker of this document signed it in my presence. He or she is personally known to me and I believe him or her to be capable of making health care decisions, to understand this document, and to have signed it voluntarily.

- I am not related by blood or marriage to him or her.
- I am not now entitled to receive any portion of his or her estate, either by will or by operation of law, or as a result of any claim against him or her.
- I am not his or her attending physician or an employee of that physician or of a health facility in which he or she is a patient.

Witness 1	Witness 2
Signature	Signature
Ann M Lueders	Brian Nichols
Name	Name
5094278238	541-490-7559
Phone	Phone
11271 Wind River Rd Carson, WA 98610	PO Box 229 North Bonneville WA 98639
Address	Address

****

I am Paul Pearce — 9/14/17

My Signature — Date

Notarization

State of Washington

County of Skamania

I certify that I know or have satisfactory evidence that Paul Pearce, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on 09/14/2017.

Jayne Borden
SIGNATURE OF NOTARY

Jayne Borden
PRINT NAME OF NOTARY

JAYNE I. BORDEN
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
FEBRUARY 15, 2019

NOTARY PUBLIC for the State of Washington.

My commission expires 02/15/2019.

EXHIBIT A

Contact Information for Agent and Alternates as of the Date of Signing

My Agent's Name	Kay Roeder		
Address	1010 Chenowuth PO Box 325 North Bonneville, WA ~~98671~~ 98639		
Phone	509-427-5774	Email	Casey@Skamania.Org

My Agent's Name			
Address			
Phone		Email	

My Alternate Agent's Name	Douglas Slyter		
Address	2107 Franklin Camas, WA 98607		
Phone	360.608-2256	Email	Slydug@yahoo.com

My Alternate Agent's Name			
Address			
Phone		Email	