DURABLE POWER OF ATTORNEY AND HEALTHCARE DIRECTIVE QUESTIONNAIRE

Skip PERSONAL INFORMATION section if you have already completed a Will/Trust Questionnaire

PERSONAL INFORMATION SECTION:

YOUR PERSONAL INFORMATION	YOUR SPOUSE'S PERSONAL INFORMATION
Name	Name
Address	Address
City	City
State	State
Zip E-mail	Zip
County	County
Telephone # Cell#	Telephone # Cell#
Date of Birth	Date of Birth
S.S. #	S.S.#
Gender: ☐ Male ☐ Female	Gender: ☐ Male ☐ Female

DURABLE POWER OF ATTORNEY

Effective date of your Power of Attorney ☐ only when incapacitated ☐ immediately

My incapacity shall be determined by:

- ☐ One doctor chosen by my attorney-in-fact
- ☐ One doctor I name: _____
- ☐ Two doctors chosen by my attorney-in-fact
- ☐ Two doctors I name: _____

My attorney in fact shall be: ☐1 person ☐2 people ☐3 people ☐Co-Agents

Attorney-in-Fact (1)
Name: _____
Address _____
Telephone: _____

Attorney-in-Fact (2) ☐ (check if alternate for 1) ☐Check if co-agent
Name: _____
Address _____
Telephone: _____

Attorney-in-Fact (2) ☐ (check if alternate for 2) ☐ Check if co-agent
Name: _____
Address _____
Telephone: _____

If you are appointing co-agents, please describe how they should serve:

_____

_____

_____

Do you require your attorney-in-fact to make periodic reports? ☐ No ☐ Yes. If yes, who should the reports be submitted to: _____

DURABLE POWER OF ATTORNEY AND HEALTHCARE DIRECTIVE QUESTIONNAIRE

HEALTHCARE DIRECTIVE

If you are diagnosed as having a terminal condition and can no longer direct your medical care:
(Check one):

☐ I do not want any life-prolonging procedures and
- ☐ DO ☐ DO NOT want food and water artificially administered
- ☐ DO ☐ DO NOT want all pain reduction and/or comfort care

☐ I want some life-prolonging procedures, but not others (check all desired):
- ☐ Blood and Blood products ☐ CPR ☐ Diagnostic tests ☐ Dialysis
- ☐ Drugs ☐ Respirator ☐ Surgery

☐ I want all life-prolonging procedures

If you are diagnosed as being in a permanent coma and can no longer direct your medical care:
(Check one):

☐ I do not want any life-prolonging procedures and
- ☐ DO ☐ DO NOT want food and water artificially administered
- ☐ DO ☐ DO NOT want all pain reduction and/or comfort care

☐ I want some life-prolonging procedures, but not others (check all desired):
- ☐ Blood and Blood products ☐ CPR ☐ Diagnostic tests ☐ Dialysis
- ☐ Drugs ☐ Respirator Surgery

☐ I want all life-prolonging procedures

I desire the following representative to oversee my wishes: Attorney-in-Fact ☐ #1 ☐ #2 ☐ #3
I desire the following representative to act as an alternate: Attorney-in-Fact ☐ #1 ☐ #2 ☐ #3

FEMALES ONLY: If I am pregnant when my healthcare directive is considered:
☐ I direct it be given no effect during my pregnancy ☐ I direct that it be carried out

ACKNOWLEDGMENT AND AUTHORIZATION

I understand that the Legal Document Assistant (LDA) preparing my documents is NOT an attorney, cannot select forms and DOES NOT give legal advice. I hereby direct the Legal Document Assistant to type and perform certain services as outlined in the Contract for Services which we each executed regarding this matter. I further declare that the foregoing information which I have provided is, to the best of my knowledge, true and correct.

Dated:_____ _____

SIGNATURE