NON-DURABLE MEDICAL POWER OF ATTORNEY

SECTION 1 — PRINCIPAL INFORMATION

Full Name: _____
Address: _____
Phone / Email: _____

SECTION 2 — AGENT INFORMATION

Full Name: _____
Relationship: _____
Phone / Email: _____

SECTION 3 — AUTHORITY

I grant my agent authority to make healthcare decisions temporarily. This power does not remain in effect upon incapacity.
(Type additional details in the space provided below:)

Principal Signature: _____
Printed Name: _____
Date: _____

Witness 1 Name: _____
Witness 1 Signature: _____

Witness 2 Name: _____
Witness 2 Signature: _____

SECTION 4 — NOTARY ACKNOWLEDGMENT
State of Missouri
County of Jackson

On this _____ day of _____, 20____, before me, the undersigned Notary Public, personally appeared_____, who is known to me or proved to me through satisfactory evidence of identification to be the person whose name is subscribed to the within instrument, and acknowledged that they executed the same for the purposes therein stated.

Notary Signature
_____

Printed Name
_____

My Commission Expires
_____

Notary Public Seal