

HEALTH CARE POWER OF ATTORNEY & LIVING WILL QUESTIONNAIRE

Living Will – a document that establishes your intent to either refuse or receive certain medical treatment in the event you enter a condition of permanent unconsciousness or terminal illness that could result in death in a reasonably short time.

Health Care Power of Attorney – a document in which you appoint someone you trust as an agent to make health care decisions for you in the event that you become incapacitated or otherwise unable to make health care decisions for yourself. The agent is to make these decisions in accordance with the guidelines provided for in the document.

If you would like a Living Will and Health Care Power of Attorney, please provide the following information:

Name (first, middle, last): _____

Address (street, city, state, zip code): _____

Primary Agent you wish you appoint:

Name (first, middle, last): _____

Address (street, city, state, zip code): _____

Phone Number(s) (include area code): _____

Alternate Agent: You must choose at least one agent. You are encouraged to list a first and second alternate to act as your agent in the event your primary agent is unable to act.

First Alternate Agent (to act if primary agent is unable to act)

Name (first, middle, last): _____

Address (street, city, state, zip code): _____

Phone Number(s) (include area code): _____

Second Alternate Agent (to act if both primary and first alternate agents are unable to act)

Name (first, middle, last): _____

Address (street, city, state, zip code): _____

Phone Number(s) (include area code): _____