

DURABLE POWER OF ATTORNEY

DO YOU WISH TO **APPOINT** SOMEONE TO **TAKE CARE** OF YOUR AFFAIRS ON YOUR BEHALF IN THE EVENT YOU BECOME **INCAPACITATED** OR **UNABLE TO COMMUNICATE** YOUR DECISIONS?

YES OR NO

IF YES, **WHOM** DO YOU WISH TO NAME AS YOUR **AGENT**?

NAME: _____ **RELATIONSHIP TO YOU** _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____ - _____

NAME AN ALTERNATE AGENT, IF THIS PERSON IS **UNABLE TO SERVE** AS YOUR AGENT:

NAME: _____ **RELATIONSHIP TO YOU** _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____ - _____

ARE THERE ANY **POWERS** YOU WISH TO SPECIFICALLY **GRANT** OR **DENY** TO THIS AGENT?

MAKE GIFTS ON YOUR BEHALF?

YES OR NO

IF YES, TO YOUR DESCENDANTS ONLY

YES OR NO

SPECIFIC POWERS RELATED TO A **RETIREMENT PLAN OR INDIVIDUAL RETIREMENT ACCOUNT (IRA)?**

YES OR NO

TO **FILE TAXES** ON YOUR BEHALF?

YES OR NO

SELL SPECIFIC REAL ESTATE ON YOUR BEHALF?

YES OR NO

IF **YES**, WHAT **REAL ESTATE**? _____

IF APPLICABLE, ADDRESS: _____

CITY, STATE, ZIP CODE _____

ANY OTHER POWERS?

YES OR NO

IF **YES**, WHAT _____

INFORMATION ABOUT YOU

NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____ - _____

HEALTH CARE & INCAPACITY DECISION MAKING WORKSHEET

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY ANY QUESTIONS YOU HAVE CAN BE ANSWERED BY YOU ATTORNEY

LIVING WILL

DO YOU WISH FOR A **LIVING WILL** TO BE PREPARED FOR YOU? **YES OR NO**

IN THE EVENT YOU HAVE A **TERMINAL CONDITION**, BECOME **COMATOSE** OR ENTER A PERSISTENT VEGITATIVE STATE, DO YOU **WANT**

LIFE SUPPORT? **YES OR NO**

NUTRITION AND HYDRATION? **YES OR NO**

DURABLE HEALTH CARE POWER OF ATTORNEY

DO YOU WISH TO **APPOINT** SOMEONE TO **MAKE HEALTH CARE DECISIONS** ON YOUR BEHALF IN THE EVENT YOU BECOME **INCAPACITATED** OR **UNABLE TO COMMUNICATE** YOUR DECISIONS? **YES OR NO**

IF YES, **WHOM** DO YOU WISH TO NAME AS YOUR **AGENT**?

NAME: _____ **RELATIONSHIP TO** _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____ - _____

IF YES, WHAT _____

NAME AN ALTERNATE AGENT, IF THIS PERSON IS **UNABLE TO SERVE** AS YOUR AGENT:

NAME: _____ **RELATIONSHIP TO** _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____ - _____

DO YOU WANT YOUR AGENT AUTHORIZED TO DONATE YOUR ORGANS? **YES OR NO**

IF YES, IS THE AUTHORITY FOR (CIRCLE ONE)
TRANSPLANT ONLY **OR** ANY MEDICAL PURPOSE (Research, etc.)

DO YOU WISH TO EXPRESS A PREFERENCE **TO DIE AT HOME**, RAHTER THAN IN A HOSPITAL?

YES OR NO