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: ____________________

CALDA

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

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