POWER OF ATTORNEY and ADVANCE MEDICAL DIRECTIVE

Client Information

Client Name: _____

Address: _____

City/County/State/Zip:_____

Telephone number: (h)_____ (o)_____ (c)_____

Email: _____

DOB: _____ SSN: _____

Financial Agent 1

Name: _____

Relationship (to client): _____

Address: _____

City/County/State/Zip:_____

Telephone number: (h)_____ (o)_____ (c)_____

Email: _____

Financial Alternate Agent

Name: _____

Relationship (to client): _____

Address: _____

City/County/State/Zip:_____

Telephone number: (h)_____ (o)_____ (c)_____

Email: _____

MEDICAL Agent 1(if different than financial)

Name: _____

Relationship (to client): _____

Address: _____

City/County/State/Zip:_____

Telephone number: (h)_____ (o)_____ (c)_____

Email: _____

MEDICAL Alternate Agent (if different than financial)

Name: _____

Relationship (to client): _____

Address: _____

City/County/State/Zip:_____

Telephone number: (h)_____ (o)_____ (c)_____

Email: _____

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