

POWERS OF ATTORNEY
and
ADVANCE MEDICAL DIRECTIVES

Client Information

Client Name: _____

Address: _____

City/County/State: _____

Telephone number: _____

Email: _____

DOB: _____ SSN: _____

Financial Agent 1

Name: _____

Relationship (to client): _____

Address: _____

City/County/State: _____

Financial Alternate Agent

Name: _____

Relationship (to client): _____

Address: _____

City/County/State: _____

MEDICAL Agent 1(if different than financial)

Name: _____

Relationship (to client): _____

Address: _____

City/County/State: _____

MEDICAL Alternate Agent (if different than financial)

Name: _____

Relationship (to client): _____

Address: _____

City/County/State: _____