

MEDICAL POWER OF ATTORNEY (HEALTHCARE PROXY)

1. Principal Information

Full Name

Address

Phone Number

Date of Birth

2. Agent (Healthcare Proxy) Information

Full Name

Address

Phone Number

Relationship to Principal

3. Alternate Agent (Optional)

Full Name

Address

Phone Number

4. Grant of Authority

Special instructions or limitations, if any:

(If none, write 'None')

5. Duration

Effective Date and Expiration (if any):

E.g., 'This power of attorney becomes effective upon my incapacity and remains in effect unless revoked.'

6. Signature and Acknowledgment

Principal's Signature

Date

Witnesses

Witness #1 Signature

Date

Witness #1 Printed Name

Witness #2 Signature

Date

Witness #2 Printed Name

Note: Depending on your jurisdiction, notarization may be required.