DURABLE POWER OF ATTORNEY FOR *HEALTHCARE*
INTAKE INFORMATION

DESIGNATED ATTORNEY-IN-FACT (Person to whom Power of Attorney is given):

NAME:_____

ADDRESS:_____

CITY/COUNTY/STATE/ZIP:_____

PHONE:_____ RELATIONSHIP:_____

FIRST ALTERNATE:_____

ADDRESS:_____

CITY/COUNTY/STATE/ZIP:_____

PHONE:_____ RELATIONSHIP:_____

SECOND ALTERNATE:_____

ADDRESS:_____

CITY/COUNTY/STATE/ZIP:_____

PHONE:_____ RELATIONSHIP:_____