Medical Power of Attorney

Principal: [Your Full Name]

Address: [Your Address]

Date: [Date]

Designation of Health Care Agent

I, [Your Full Name], hereby designate the following individual as my health care agent to make medical decisions on my behalf, in accordance with my wishes:

Agent's Name: [Agent's Full Name]

Agent's Address: [Agent's Address]

Agent's Phone Number: [Agent's Phone Number]

Durability of Power of Attorney

This Medical Power of Attorney shall remain in effect even if I become incapacitated and shall continue until revoked by me in writing.

Signature

_____

[Your Full Name]

Witnessed by:

_____

[Witness Name]