L. THEODORE HOPPE, JR.
ATTORNEY AT LAW

DURABLE HEALTHCARE POWER OF ATTORNEY AND LIVING WILL QUESTIONNAIRE

Name: _____

Address: _____

City: _____ State _____ Zip Code _____

Telephone No. _____ Email Address _____

Date of Birth: _____

AGENT: Your Medical Power of Attorney/Durable Power of Attorney for Healthcare:

Name: _____ _____

Address: _____ _____

City: _____ State _____ Zip Code _____

Telephone No. _____ Email Address _____

Relationship to you: _____ _____

ALTERNATE AGENT:

Name: _____ _____

Address: _____ _____

City: _____ State _____ Zip Code _____

Telephone No. _____ Email Address _____

Relationship to you: _____ _____

GUIDANCE FOR HEALTH CARE AGENT (Optional)

If you have an end-stage medical condition or other extreme irreversible medical condition, your goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.): _____

_____

_____

2 S. Orange Street, Suite 215
Santander Bank Building
Media, PA 19063

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