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HEALTH CARE POWER OF ATTORNEY PDF FILLABLE FORM

Please submit the following information to initiate a consultation with a VW attorney regarding establishing a health care power of attorney.

Prior to submitting information via this form, please review our web site terms and conditions which you can find at vwattys.com. By submitting information via this form, you acknowledge that you have read and agree to our web site terms and conditions. If you would like information about how to submit this form to us in a secure manner, please contact us at info@vwattys.com.

Note: If you need more space to complete the questions below, please feel free to attach additional sheets.

Full Legal Name of Principal (person for whom power of attorney is being completed):

_____ _____ _____

Principal Email Address: _____

Principal Street Address: _____ _____ _____ _____

Principal City of Residence: _____

Principal State of Residence: _____

Principal Zip Code: _____

Principal County of Residence: _____

Primary Phone Number: _____ ◉ Cell ○ Home ○ Work

Secondary Phone Number: _____ ○ Cell ○ Home ○ Work

Full Legal Name of Health Care Agent: _____

Health Care Agent Address: _____ _____ _____ _____

Health Care Agent Phone Number: _____ ○ Cell ○ Home ○ Work

Full Legal Name of Alternate Health Care Agent: _____

Alternate Health Care Agent Address: _____

Alternate Health Care Agent Phone Number: _____ ○ Cell ○ Home ○ Work

Does Principal have any special directions to agent?

After this document has been completed, please email it to info@vwattys.com or fax it to (402) 504-1935.