

Law Office of David Pickard

ATTORNEY AT LAW

<u>Durable Power of Attorney & Advanced Healthcare Directive Questionnaire</u>

| 1. | Information about you: Full Name: Former Names/A Address: | lias: |
|----|---|---|
| 2. | List the name, address your Power of Attorney: | and telephone number of the person you would like to designate as |
| | Power of Attorney | Name: Address: |
| | | Phone: |
| | Alt. Power of Attorney | Name:Address: |
| | | Phone: |
| 3. | Please choose among to prolonging your life: | ne following which decision you would like to be made with regards to |
| | an incurat relatively s certainty, | ot to Prolong Life: I desire that my life not be prolonged if (1) I have le and irreversible condition that will result in my death within a short time; (2) I become unconscious and, to a reasonable medical will not regain consciousness; or (3) the likely risks and burdens of would outweigh the expected benefits |
| | within the | Prolong Life: I desire that my life be prolonged as long as possible limits of generally accepted health care standards. 13215 Penn Street • Suite 300 • Whittier, CA 90602 |



| 4. | Please choose among the following which decision you would like to be made with regards to relieving you of pain: | | |
|----|---|---|--|
| | [] | Relief from Pain: I direct that treatment for alleviation of pain or discomfort be provided at all times possible, even if it hastens my death. | |
| | [] | Specific Instructions: | |
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| 5. | Name, add | ress and phone number of your primary care physician? | |