PARSONAGE VANDENACK WILLIAMS LLC
Attorneys at Law
5332 S. 138th Street, Suite 100
Omaha, NE 68137
(402) 504-1300 Telephone
(402) 504-1935 Facsimile
www.pvwlaw.com

HEALTH CARE POWER OF ATTORNEY PDF FILLABLE FORM

Please submit the following information to initiate a consultation with a PVWLaw 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 www.pvwlaw.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@pvwlaw.com.

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

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

_____ _____ _____

Principal City of Residence: _____

Principal County of Residence: _____

Principal State of Residence: _____

Health Care Agent Name: _____ _____ _____

Health Care Agent Address: _____ _____ _____ _____

Health Care Agent Phone Number:

_____ ◯ Cell ◯ Home ◯ Work

Alternate Health Care Agent Name: _____ _____ _____

Alternate Health Care Agent Address: _____ _____ _____

_____

Alternate Health Care Agent Phone Number:

_____ ◯ Cell ◯ Home ◯ Work

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Does Principal have any special directions to agent?

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