HEALTH CARE INFORMATION

I provide the following information to assist my health care agents in the event of my incapacity (attach additional sheets as necessary):

HEALTH INFORMATION (If none in any category, write "none"):
Previous surgeries (type, year, surgeon): ______________________________
Health problems: ______________________________
Current medications:
____
Allergies (including medications): ______________________________
Other: ______________________________
____
____
____

PHYSICIANS:

Name	Address	Telephone	Specialty	Year of Last Visit

INSURANCE (Health and Long-Term Care):

Name of Carrier	Name of Agent	Telephone	Description of Policy	Premium amount, mode (draft, employer, etc.)

HEALTH CARE PREFERENCES (include long-term care): ______________________________

____

____

____

____

____

____
____
____

(Mark through the following sentence if it is not your desire.) If it is determined that I have an irreversible terminal condition caused by injury or illness and that my death will result without the application of mechanical life-sustaining procedures, I desire that such procedures be withheld or withdrawn when directed by my health care agent.

Date: ____________________________ Signature: ___________________________________