Financial Power of Attorney

I want to appoint an attorney to act should I become physically or mentally incapable

Yes/No

If yes, please tick when you wish the power of attorney to begin to operate

☐ IMMEDIATELY or

☐ CERTIFICATION BY TWO DOCTORS IN WRITING THAT I AM LEGALLY INCAPABLE

Attorney 1 – Full name:	
Age:	
Residential address:	……..…… …….. State: ……. P/code ……..…
Attorney 2 – Full name:	
Age:	
Residential address:	……..…… …….. State: ……. P/code ……..…
Attorney 2 is to be: (please tick)	☐ Joint attorney (Attorneys must act together) ☐ Joint & several attorney (Attorneys can act independently of each other) ☐ Substitute attorney (if Attorney 1 cannot act)

Medical Power of Attorney

I want crucial medical treatment decisions made by someone I trust if I am incapable of making them myself

Yes/No

Agent 1 – Full name:	
Relationship to you: (i.e. sister)	
Agent 1's occupation:	
Agent 1's date of birth:	
Agent 1's residential address:	……..…… …….. State: ……. P/code ……..…

Alternate Agent – Full name:	
Relationship to you: (i.e. sister)	
Alternate Agent's occupation:	
Alternate Agent's date of birth:	
Alternate Agent's residential address:	……..…… …….. State: ……. P/code ……..…