

JOHNNY W. THOMAS, LAW OFFICE, P.C.
MEDICAL POWER OF ATTORNEY WORKSHEET

You:

Name: _____

Address: _____

City, State & Zip: _____

Home # _____ **Wk#** _____ **Cell#** _____

Who would you like to give Medical Power of Attorney to:

Name: _____

Address: _____

City, State & Zip: _____

Home # _____ **Wk#** _____ **Cell#** _____

Alternate: 1

Name: _____

Address: _____

City, State & Zip: _____

Home # _____ **Wk#** _____ **Cell#** _____

Alternate: 2

Name: _____

Address: _____

City, State & Zip: _____

Home # _____ **Wk#** _____ **Cell#** _____