TL | TAMBLYN LAW, PLLC

WILL INTAKE FORM

DATE:_____

NOTICE: Tamblyn Law PLLC does not give tax advice. You must discuss those issues with a specialized attorney.

Please fill out the following information prior to your appointment with our office. We will use this information to draft a Simple Will (distributing your assets, setting out burial requests, guardian for minor children, etc.), a Medical and Financial Power of Attorney (selecting someone to make medical and financial decisions for you in the event you are unable to do so yourself), and a Living Will/Advanced Health Care Directive (electing or declining life-prolonging heroic measures).We will enter a fee agreement for these services before our services commence.

PERSONAL INFORMATION:

Name: _____

Address:

_____

City:_____ State, Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone: _ _____ Date of Birth:_ _____

Email:_____

Marital Status:_____ Spouse's Name:_____

PERSONAL REPRESENTATIVE INFORMATION:

This person follows your instructions and makes sure your wishes are followed.

Name: _____

Address:_____

City:_____ State, Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone: _ _____ Date of Birth:_ _____

ALTERNATE PR INFORMATION:

This person will serve as your agent if your agent, named above, is unable or unwilling to serve.

Name: _____

Address:_____

City:_____ State, Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone: _ _____ Date of Birth:_ _____

___YES___ NO I would like to authorize my PR to get copies of my medical records at any time, even when I can speak for myself.

__YES __NO I would like to authorize my PR to admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

__YES __ NO I would like to place the limits or expansions on the powers of my health care agent. (*Specify below.*)

Limits/Expansions:_____

_____

__YES __ NO I would like to authorize my PR to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

__YES __NO If I have not otherwise agreed to organ donation, I would like to authorize my PR to consent to the donation of my organs for the purpose of organ transplantation.

__YES __ NO I would like to nominate my agent or alternate agent to serve as my guardian in the event that I become incapacitated. *Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary.*

IF THERE ARE NO MINOR CHILDREN, SKIP THE NEXT PAGE

MINOR CHILD(REN) INFORMATION:

CHILD 1
NAME _____
DOB _____
ADDRESS _____
SS# _____

CHILD 2
NAME _____
DOB _____
ADDRESS _____
SS# _____

CHILD 3
NAME _____
DOB _____
ADDRESS _____
SS# _____

CHILD 4
NAME _____
DOB _____
ADDRESS _____
SS# _____

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TRUSTEE/CONSERVATOR: *This person manages money on behalf of your minor children.*
Name:

_____
Address:_____
City:_____
State,_____Zip:_____
Home Phone:_____ Cell
Phone:_____
Work Phone: _ _____ Date of Birth:_ _____
Relationship to
you:_____

ALTERNATE TRUSTEE/CONSERVATOR:
Name:

_____
Address:_____
City:_____State____Zip:_____
Home Phone:_____
Cell Phone:_____Work Phone: _ _____
Date of Birth:_ _____
Relationship to
you:_____

GUARDIAN: *This person physically cares for your minor children.*
Name:

_____
Address:_____
City:_____State____Zip:_____
Home Phone:_____Cellphone:_____
Work Phone: _ _____ Date of Birth:_ _____
Relationship to
you:_____

ALTERNATE GUARDIAN:
Name:

_____
Address:_____
City:_____State_____Zip:_____
_____

Home Phone:_____CellPhone:_____
Work Phone: _ _____ Date of Birth: _____
Relationship to
you:_____

MISCELLANEOUS INFORMATION:
Please indicate how and to whom you would like your property distributed:

Please indicate if you have any specific burial/cremation requests:

LIVING WILL (ADVANCE HEALTH CARE DIRECTIVE) INFORMATION:
A living will gives instructions to doctors and family members in the event you are terminally ill and unable to speak for yourself. A living will sets out your wishes with regard to life sustaining equipment and/or heroic action being used to prolong your life.

Please select ONE option from the following.
If at any time I should have an injury, disease, or illness, which is certified in writing to be a terminal condition or persistent vegetative state by two (2) physicians who have personally examined me, and in the opinion of those physicians the application of life-sustaining procedures would serve only to unnaturally prolong the moment of my death and to unnaturally postpone or prolong the dying process,

___ OPTION 1: I choose to let my agent decide.

___OPTION 2: I choose to prolong life.

___OPTION 3: I choose not to receive care for the purpose of prolonging life.

If Option 3 is selected, please select either (A) or (B):

___(A) I put no limit on the ability of my health care provider or agent to withhold or withdraw life sustaining care.

___(B) My health care provider should withhold or withdraw life-sustaining care if at least one of the following conditions is met (check all that apply):
_____ I have a progressive illness that will cause death.
_____ I am close to death and am unlikely to recover.
_____ I cannot communicate and it is unlikely that my condition will improve.
_____ I do not recognize my family or friends and it is unlikely that my condition will improve.
_____ I am in a persistent vegetative state.
ADDITIONAL INSTRUCTIONS:
_____
_____
_____
_____
_____
_____
_____

FOR ATTORNEY TO COMPLETE
REMARKS/INSTRUCTIONS:_____

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