My name:

.....

Date of birth: .....

My Champion:
(the person I trust to make medical decisions for me when I am unable)

Name: .....

Relationship: .....

Phone:

Home: .....

Work: .....

Cell: .....

continued

NOVANT® HEALTH

I have a Health Care Power of Attorney (HCPOA) naming this person as my agent. ☐ Yes ☐ No

I have a living will. ☐ Yes ☐ No

If yes, a copy of my documents can be found .....

.....

Specific instructions:

.....

.....

My doctor's name:

.....

My doctor's phone number:

.....

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