

## NOTICE TO HEALTHCARE PROVIDERS

I, \_\_\_\_\_, have executed a

Living Will

Durable Power of Attorney for Health Care

and have given a copy of such document(s) to:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

YOUR NAME:

\_\_\_\_\_

ADDRESS:

\_\_\_\_\_

\_\_\_\_\_

PHONE ( ) \_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_