

ESTATE PLANNING QUESTIONNAIRE

We prefer clients to complete this questionnaire to the extent possible. We find it most helpful to receive completed questionnaires, at least with respect to the financial information, prior to our initial meeting with clients. Our attorneys will rely on the information provided in this form to develop our recommendations for your estate plan, however, estimates or approximate values are acceptable. Only one questionnaire needs to be completed for a couple.

By typing (or writing) your name(s) in the spaces below, you acknowledge the foregoing. **All answers will be kept confidential.** If you have any questions please contact us at 301-340-2020.

CONTACT INFORMATION - CLIENT 1				
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	First Name	Middle Name	Last Name	Suffix
<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss				
Mailing Address 1				
Mailing Address 2				
City			State	ZIP
Home Phone ()	Business Phone ()		Mobile Phone ()	How long have you been living in your current state or district?
DOB __ / __ / ____	Personal E-mail		Business E-mail	
Occupation			Annual Income (All sources)	
State of Health				
Previous Marriage(s): <i>Please specify if ended in separation, divorce or death.</i> *				
Country(ies) of Citizenship			Nickname/Other/Former Names	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Civil Union <input type="checkbox"/> Other	Do you have any children? <input type="checkbox"/> Y <input type="checkbox"/> N	How many living children?	Please provide the names and date of birth for any deceased children.
Do you have any genetic material stored? <input type="checkbox"/> Y <input type="checkbox"/> N	If so, please provide details on genetic material.	Do you plan to have or adopt any (additional) children? <input type="checkbox"/> Y <input type="checkbox"/> N		

*Please specify the name of your former or late partner/spouse. Please note if you have a continuing financial obligation.

CONTACT INFORMATION - CLIENT 2

Mr. Ms. Dr. First Name Middle Name Last Name Suffix
 Mrs. Miss

Mailing Address 1

Mailing Address 2

City State ZIP

Home Phone () Business Phone () Mobile Phone () How long have you been living in your current state or district?

DOB ___ / ___ / _____ Personal E-mail Business E-mail

Occupation Annual Income (All sources)

State of Health

Previous Marriage(s): Please specify if ended in separation, divorce or death. *

Country(ies) of Citizenship Nickname/Other/Former Names

Gender M F Status Single Separated Widowed Married Divorced Partnered Civil Union Other
 Do you have any children in addition to those noted above? Y N How many additional living children? Please provide the names and date of birth for any additional deceased children.

Do you have any genetic material stored? Y N If so, please provide details on genetic material.

Please specify the name of your former or late partner/spouse. Please note if you have a continuing financial obligation.

CONTACT INFORMATION - CHILD 1

Mr. Ms. Dr. First Name Middle Name Last Name Suffix
 Mrs. Miss

Child of

Mailing Address 1 (if different than Client 1)

CONTACT INFORMATION - CHILD 1

Mailing Address 2

City		State	ZIP
Home Phone ()	Business Phone ()	Mobile Phone ()	DOB -- / -- / ----
Personal E-mail		Business E-mail	
How does your child identify?	Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Civil Union <input type="checkbox"/> Other	Spouse/Partner Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss
	Child's Child 1		DOB -- / -- / ----
Child's Child 2	DOB -- / -- / ----		
Child's Child 3	DOB -- / -- / ----		
Comments/Special Considerations including government benefits			

CONTACT INFORMATION - CHILD 2

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	First Name	Middle Name	Last Name	Suffix
Child of				
Mailing Address 1 (if different than Client 1)				
Mailing Address 2				
City		State	ZIP	
Home Phone ()	Business Phone ()	Mobile Phone ()	DOB -- / -- / ----	
Personal E-mail		Business E-mail		

CONTACT INFORMATION - CHILD 2

How does your child identify?	Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Civil Union <input type="checkbox"/> Other	Spouse/Partner Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss
Child's Child 1			DOB ___/___/_____
Child's Child 2			DOB ___/___/_____
Child's Child 3			DOB ___/___/_____
Comments/Special Considerations			

CONTACT INFORMATION - CHILD 3

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	First Name	Middle Name	Last Name	Suffix
Child of				
Mailing Address 1 (if different than Client 1)				
Mailing Address 2				
City		State	ZIP	
Home Phone ()	Business Phone ()	Mobile Phone ()	DOB ___/___/_____	
Personal E-mail		Business E-mail		
How does your child identify?	Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Civil Union <input type="checkbox"/> Other	Spouse/Partner Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	
Child's Child 1			DOB ___/___/_____	
Child's Child 2			DOB ___/___/_____	
Child's Child 3			DOB ___/___/_____	

Comments/Special Considerations

CONTACT INFORMATION - CHILD 4

Mr. Ms. Dr. First Name Middle Name Last Name Suffix
 Mrs. Miss

Child of

Mailing Address 1 (if different than Client 1)

Mailing Address 2

City	State	ZIP
Home Phone ()	Business Phone ()	Mobile Phone ()
Personal E-mail		DOB __ / __ / ____
Business E-mail		

How does your child identify?	Status	Spouse/Partner Name	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.
	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Civil Union <input type="checkbox"/> Other		<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss
Child's Child 1			DOB __ / __ / ____
Child's Child 2			DOB __ / __ / ____
Child's Child 3			DOB __ / __ / ____

Comments/Special Considerations

CONTACT INFORMATION - OTHER DEPENDENTS, BENEFICIARIES & CHARITIES

Mr. Ms. Dr. First Name Middle Name Last Name Suffix
 Mrs. Miss

Relationship and To Whom (e.g. mother to Client 1)

Comments/Special Considerations

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	First Name	Middle Name	Last Name	Suffix
<input type="checkbox"/> Mrs. <input type="checkbox"/> Miss				

Relationship and To Whom (e.g. mother to Client 1)

Comments/Special Considerations

Do you have any special requests for distributions to charities or other beneficiaries?

DOCUMENTS AND AGREEMENTS (please bring with you to your first meeting with our attorneys)

<input type="checkbox"/> I/We have a Will	State domiciled when signed	Date Signed
<input type="checkbox"/> I/We have a Revocable Trust	State domiciled when signed	Date Signed
<input type="checkbox"/> I/We have a Financial Power of Attorney	State domiciled when signed	Date Signed
<input type="checkbox"/> I/We have an Advance Medical Directive	State domiciled when signed	Date Signed
<input type="checkbox"/> I/We created an Irrevocable Trust Agreement(s)	State domiciled when signed	Date Signed
<input type="checkbox"/> I/We have a Prenuptial/Postnuptial Agreement	State domiciled when signed	Date Signed
<input type="checkbox"/> I/We have made substantial gifts	Details	
<input type="checkbox"/> I/We have filed Gift Tax Return(s) (IRS Form 709)		
<input type="checkbox"/> I/We are a beneficiary under an existing Irrevocable trust(s)	Details	
<input type="checkbox"/> I/We have Buy-Sell/Redemption Agreement(s)	Details	
<input type="checkbox"/> I/We are anticipating a substantial inheritance	Details	
<input type="checkbox"/> I/We own property in other states.	Please list any additional states and nature of property.	
<input type="checkbox"/> I/We own property in foreign countries.	Please list any additional countries and nature of property.	

CLIENT PROFESSIONAL ADVISORS

Name of Financial Advisor	Phone ()	<input type="checkbox"/> I/We would like you to recommend a Financial Advisor
Name of Accountant	Phone ()	<input type="checkbox"/> I/We would like you to recommend an Accountant
Name of Insurance Agent	Phone ()	<input type="checkbox"/> I/We would like you to recommend an Agent
Names of Financial Institutions Where You Have Primary Accounts		

FINANCIAL INFORMATION

Please list approximate values of assets and be specific as to how these assets are titled. Include all assets which are titled in your name(s) or Revocable Trust(s). Assets which are owned jointly with rights of survivorship, tenants by the entirety, or tenants in common should be listed in the appropriate column below. Estimated values are acceptable. If an estimate is unavailable, please indicate "not available" or "N/A" in the applicable column. PLEASE DISCLOSE ALL WORLDWIDE PROPERTY.

I/We own assets held in a foreign country

If so, please provide details

I/We have made contributions to 529 Education Savings Plan(s)

I/We have made contributions to a Custodial UGMA/UTMA Account(s)

I/We have made contributions to an ABL Plan

RETIREMENT ACCOUNTS: IRA, 401(k), 403 (b), PROFIT SHARING, SEP, ETC.

Please list all retirements accounts and pension plans below.

Note: If you have changes to make to your beneficiary designations, please obtain the designation form(s) from the account administrator of that account and bring with you to the meeting with your attorney.

ASSETS	CLIENT 1	BENEFICIARY (Primary/Contingent)	CLIENT 2	BENEFICIARY (Primary/Contingent)
Account 1 Type	Approx Value		Approx Value	
Account 2 Type	Approx Value		Approx Value	
Account 3 Type	Approx Value		Approx Value	
Account 4 Type	Approx Value		Approx Value	

ASSETS - List Nature and Amount of Defined Benefit Plan (e.g. Joint & Survivor Annuity, Civil Service, Military, etc)

NON-RETIREMENT ASSETS

Please list all bank, brokerage accounts and/or investments approximate values.

ASSETS	CLIENT 1	CLIENT 2	JOINT WITH SPOUSE	JOINT WITH OTHER(S)
Cash	Approx Value	Approx Value	Approx Value	Approx Value
Brokerage Account	Approx Value	Approx Value	Approx Value	Approx Value
Money Market	Approx Value	Approx Value	Approx Value	Approx Value
CDs	Approx Value	Approx Value	Approx Value	Approx Value
Govt. Securities (EE, HH Bonds or IBond)	Approx Value	Approx Value	Approx Value	Approx Value
Marketable Securities	Approx Value	Approx Value	Approx Value	Approx Value
Mutual Funds	Approx Value	Approx Value	Approx Value	Approx Value
Investment Real Estate (list all that apply)	Approx Value	Approx Value	Approx Value	Approx Value
Business Interest(s) (family, closely held, or otherwise)	Approx Value	Approx Value	Approx Value	Approx Value
Primary Residence	Approx Value	Approx Value	Approx Value	Approx Value
Second Residence	Approx Value	Approx Value	Approx Value	Approx Value
Artwork, Personal Property and Effects	Approx Value	Approx Value	Approx Value	Approx Value
Jewelry	Approx Value	Approx Value	Approx Value	Approx Value
Hobby Equipment and Supplies	Approx Value	Approx Value	Approx Value	Approx Value
Automobile	Approx Value	Approx Value	Approx Value	Approx Value
Automobile #2	Approx Value	Approx Value	Approx Value	Approx Value
Combined Monetary Value Of Loyalty Program Points (Frequent Flyer Miles, Credit Card Points, etc.)	Approx Value	Approx Value	Approx Value	Approx Value

ASSETS	CLIENT 1	CLIENT 2	JOINT WITH SPOUSE	JOINT WITH OTHER(S)
Cryptocurrency (please describe)	Approx Value	Approx Value	Approx Value	Approx Value
Other (please describe)	Approx Value	Approx Value	Approx Value	Approx Value
Other (please describe)	Approx Value	Approx Value	Approx Value	Approx Value

INSURANCE AND ANNUITIES

ASSETS	CLIENT 1	CLIENT 2
Permanent Life Insurance (e.g. Whole, Variable, Universal)	Value/CSV Owner Beneficiary (Primary/Contingent)	Value/CSV Owner Beneficiary (Primary/Contingent)
Term Life Insurance	Death Benefit Value Owner Beneficiary (Primary/Contingent)	Death Benefit Value Owner Beneficiary (Primary/Contingent)
Second to Die Life Insurance	Death Benefit Value Owner Beneficiary (Primary/Contingent)	Death Benefit Value Owner Beneficiary (Primary/Contingent)
Annuities not included in IRAs or other qualified plans	Current Value Guaranteed Benefit Beneficiary (Primary/Contingent)	Current Value Guaranteed Benefit Beneficiary (Primary/Contingent)

LIABILITIES - OTHER THAN SMALL DEBT(S) PAID OFF EVERY MONTH (i.e., credit cards)

ASSETS	CLIENT 1	CLIENT 2	JOINT WITH SPOUSE	JOINT WITH OTHER(S)
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Home Mortgage	Outstanding Balance	Outstanding Balance	Outstanding Balance	Outstanding Balance
Second Home Mortgage	Outstanding Balance	Outstanding Balance	Outstanding Balance	Outstanding Balance
Other <i>(please describe)</i>	Value	Value	Value	Value
Other <i>(please describe)</i>	Value	Value	Value	Value

DESIGNATION OF FIDUCIARIES

Agent or attorney-in-fact under Powers of Attorney. A Financial Power of Attorney allows you to designate one or more individuals to serve as your agent to manage your financial affairs. You may designate one or more individuals or entities to act on your behalf presently or, alternatively, only in the event of your incapacity (springing). Many clients are comfortable designating a spouse to serve presently but wish to allow other individuals to serve only upon incapacity. Some clients designate family members or entities instead of spouses to serve.

Name (Primary)	Address	City	State/Zip	Phone
Name (Alternate)	Address	City	State/Zip	Phone

Trustee of your Revocable Trusts. Many clients wish to serve as the sole Trustee of their Revocable Trust during their lifetime. Other clients wish to name their spouse to serve concurrently as Co-Trustees of each of the Revocable Trusts created (i.e., client and client's spouse will both have a separate Revocable Trust). You should also consider who would serve as the successor (co-)Trustee(s).

Name (Primary)	Address	City	State/Zip	Phone
Name (Alternate)	Address	City	State/Zip	Phone

Personal Representative. You will need to name a Personal Representative ("Executor") to administer your estate. Many individuals name a spouse, parent, child or sibling. You should name one or more individuals as the successor(s) to serve if the first person you have named cannot serve. You may also want to consider naming a bank or trust company. These persons may serve together or in consecutive order. We are available to advise/guide the Personal Representative in administering properly the probate estate and preparing and filing any federal and state estate tax returns.

Name (Primary)	Address	City	State/Zip	Phone
Name (Alternate)	Address	City	State/Zip	Phone

Guardian for Minor Children. The guardian is the person who will take care of the personal needs and upbringing of minor children upon the death of the surviving spouse. The guardian does not need to be the same person as the trustee of any trust created for the benefit of minor children. You may name different persons to take care of the personal and financial needs of your children. If you are considering naming spouses as co-guardians, please consider who should care for minor children in the event of the separation or divorce of the couple you are naming and who should serve as guardian in the event of the death of one of those spouses.

Name (Primary)	Address	City	State/Zip	Phone
Name (Alternate)	Address	City	State/Zip	Phone

Agent under Advance Medical Directive. The Advance Medical Directive/Living Will permits you to designate individuals to make health care decisions for you when you are unable to do so. You may want to name a list of individuals to serve in consecutive order. Alternatively, you may decide to name two or more individuals to serve together, by majority or unanimous consent. It is preferable to have one agent serve at a time. You may also indicate your preference regarding the extent of medical intervention.

DESIGNATION OF HEALTHCARE AGENT - CLIENT 1

Healthcare Agent Name(s) 1	Address	City	State/Zip	Phone
Healthcare Agent Name(s) 2	Address	City	State/Zip	Phone
Healthcare Agent Name(s) 3	Address	City	State/Zip	Phone

- I want my Agent(s) to serve in the order listed
 I want my Agents to serve by majority consent
 I want each Co-Agent to act independently

AGENT(S) POWERS EFFECTIVE - CLIENT 1

- I want my Agent(s) powers to be effective immediately upon signing my Advance Medical Directive.
 I want my Agent(s) powers to be effective only upon my consulting and attending physicians agreement that I have lost the ability to make decisions for myself.

Details

If you prefer you may skip the below section to discuss with your attorney during your initial meeting.

PREFERENCE IN CASE OF TERMINAL CONDITION (If death is imminent) - CLIENT 1

- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
 Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
 Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

PREFERENCE IN PERSISTANT VEGETATIVE STATE - CLIENT 1

-
- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
 - Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
 - Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
-

PREFERENCES IN CASE OF END-STAGE CONDITION - CLIENT 1

- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
 - Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
 - Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
-

PREGNANCY (IF APPLICABLE) - CLIENT 1

- I direct that my Agent shall make any determination, in my Agent's sole and absolute discretion, to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy.
 - I direct that my Agent shall make any determination, based upon my best interests, to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy.
 - I direct that my Agent shall make any determination, based upon the best interest of my infant in gestation, to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy.
-

PAIN RELIEF - CLIENT 1

- No matter what my condition, give me the medicine or other treatment I need to relieve pain (even if it might shorten my life).
 - No matter what my condition, do not give me the medicine or other treatment I need to relieve pain.
-

EFFECT OF STATED PREFERENCES - CLIENT 1

- My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements.
 - I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as I have indicated.
-

ORGAN DONATION - CLIENT 1

- Upon my death I wish to donate any needed organs, tissues or eyes.
-

Use of Organs: If any, I authorize the use of my organs, tissues or eyes for any or all of the following:

- Transplantation
 - Therapy (alleviate pain or provide comfort)
 - Any purpose authorized by law
 - Research
 - Medical Education
-

Donation of Body

I wish my body to be donated for use in a medical study program.

BODY DISPOSITION - CLIENT 1

Cremation Burial

Cemetery Plot Location

Additional Instructions & Related Wishes

DESIGNATION OF HEALTHCARE AGENT - CLIENT 2

Healthcare Agent Name(s) 1	Address	City	State/Zip	Phone
Healthcare Agent Name(s) 2	Address	City	State/Zip	Phone
Healthcare Agent Name(s) 3	Address	City	State/Zip	Phone

I want my Agent(s) to serve in the order listed
 I want my Agents to serve by majority consent
 I want each Co-Agent to act independently

AGENT(S) POWERS EFFECTIVE - CLIENT 2

I want my Agent(s) powers to be effective immediately upon signing my Advance Medical Directive.
 I want my Agent(s) powers to be effective only upon my consulting and attending physicians agreement that I have lost the ability to make decisions for myself.

Details

PREFERENCE IN CASE OF TERMINAL CONDITION (If death is imminent) - CLIENT 2

-
- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
 - Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
 - Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
-

PREFERENCE IN PERSISTANT VEGETATIVE STATE - CLIENT 2

- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
 - Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
 - Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
-

PREFERENCES IN CASE OF END-STAGE CONDITION - CLIENT 2

- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.
 - Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
 - Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.
-

PREGNANCY (IF APPLICABLE) - CLIENT 2

- I direct that my Agent shall make any determination, in my Agent's sole and absolute discretion, to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy.
 - I direct that my Agent shall make any determination, based upon my best interests, to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy.
 - I direct that my Agent shall make any determination, based upon the best interest of my infant in gestation, to provide, continue, withhold or withdraw life-sustaining measures during such pregnancy.
-

PAIN RELIEF - CLIENT 2

- No matter what my condition, give me the medicine or other treatment I need to relieve pain (even if it might shorten my life).
 - No matter what my condition, do not give me the medicine or other treatment I need to relieve pain.
-

EFFECT OF STATED PREFERENCES - CLIENT 2

- My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements.
 - I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as I have indicated.
-

ORGAN DONATION - CLIENT 2

Upon my death I wish to donate any needed organs, tissues or eyes.

Use of Organs: If any, I authorize the use of my organs, tissues or eyes for any or all of the following:

- Transplantation Therapy (alleviate pain or provide comfort) Any purpose authorized by law
 Research Medical Education
-

Donation of Body

I wish my body to be donated for use in a medical study program.

BODY DISPOSITION - CLIENT 2

- Cremation Burial
-

Cemetery Plot Location

Additional Instructions & Related Wishes
