In Case of Accident or Emergency

PCOA

End of Life Care Planning

endoflife.pcoa.org

My primary Health Care Power of Attorney is:

Name _____

Address _____

Phone Numbers _____

My secondary Health Care Power of Attorney is:

Name _____

Address _____

Phone Numbers _____

The following people have copies of my advance directives:

Name _____

Relationship_____

Phone _____

Name _____

Relationship_____

Phone _____

I have signed the following advance directives (check the box) which is/are filed with

_____:

- ☐ Living Will
- ☐ Health Care Power of Attorney
- ☐ Mental Health Care Power of Attorney
- ☐ Prehospital Medical Directive
  (Do Not Resuscitate)