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**Date:** _____ **File No:** _____

# ENDURING POWER OF ATTORNEY & PERSONAL DIRECTIVE FORM
# CONFIDENTIAL

## PERSONAL INFORMATION

| | |
|---|---|
| **Full legal name:** | |
| **List any other names you are known by:** | |
| **Date of birth:** | |
| **Do you have an existing Enduring Power of Attorney and/or Personal Directive? If so, in what jurisdiction?** | ☐ Yes<br>If yes, where? _____<br>☐ No |
| **Would you like to revoke your existing Enduring Power of Attorney and/or Personal Directive?** | ☐ Yes ☐ No |
| **Do you spend extended periods of time outside of Alberta (such as a summer home?)** | ☐ Yes ☐ No |

## INSTRUCTIONS FOR ENDURING POWER OF ATTORNEY

### a. ATTORNEY(S)

*Your attorney has the authority to do anything on your behalf that you may lawfully do, including but not limited to, exercise authority with respect to your property and financial affairs. You should ensure that your attorney agrees to being appointed to be your attorney.*

| | FULL LEGAL NAME | RELATIONSHIP | AGE | ADDRESS (City, Province, Country) |
|---|---|---|---|---|
| 1. | | | | |
| | **ALTERNATES** | | | |
| 2. | | | | |

| | | | | |
|---|---|---|---|---|
| 3. | | | | |

| | | |
|---|---|---|
| **If you have appointed more than one attorney to act jointly, must the joint attorneys act unanimously?** | ◯ Yes | ◯ No |
| **Are any of the above persons your spouse?** | ◯ Yes | ◯ No |
| **If yes, should their appointment be void if you become divorced?** | ◯ Yes | ◯ No |
| **If you became divorced from your spouse, can your attorney change any beneficiary designations that are in favour of your spouse to your estate?** | ◯ Yes | ◯ No |

## b. COMING INTO EFFECT

**Enduring Power of Attorney becomes effective**: (*Select one*)

| | |
|---|---|
| ◯ | (i) Upon my becoming mentally incapable of making reasonable judgements in respect of matters relating to my estate OR<br>(ii) Becoming physically unable to communicate decisions or judgement |
| ◯ | Immediately upon signing the Enduring Power of Attorney |

## c. DETERMINING CAPACITY

**Who can determine if you lack capacity?** (*Select one*)

| | |
|---|---|
| ◯ | Written declaration from two doctors caring for you |
| ◯ | Written declaration from the following person(s): |

| | | FULL LEGAL NAME | RELATIONSHIP | ADDRESS (City, Province, Country) |
|---|---|---|---|---|
| | 1. | | | |
| | 2. | | | |

## d. POWERS OF ATTORNEY

*Your attorney will have very wide powers to deal with your property on your behalf. You should consider very carefully whether or not you wish to impose any restrictions on the powers of your attorney.*

| | | |
|---|---|---|
| **Do you want to restrict any of the powers of your attorney?**<br><br>**If yes, what powers do you want to restrict?** | ○ Yes | ○ No |
| **Do you want your attorney to have access to your digital assets (i.e. digital devices, cell phones, email accounts, photos, videos, social network accounts, online banking, etc.) <u>during any period of incapacity</u>?** | ○ Yes | ○ No |

## e. NOTES

## INSTRUCTIONS FOR PERSONAL DIRECTIVE

### a. AGENT(S)

*Your agent has the authority to make personal and health care decisions on your behalf while you are still alive but lack the mental capacity to make those decisions. Your agent cannot make decisions concerning property and financial affairs on your behalf.*

| | FULL LEGAL NAME | RELATIONSHIP | AGE | ADDRESS (City, Province, Country) |
|---|---|---|---|---|
| 1. | | | | |
| | **ALTERNATES** | | | |
| 2. | | | | |
| 3. | | | | |

| | | |
|---|---|---|
| **If you have appointed more than one agent to act jointly, must the joint agents act unanimously?** | ○ Yes | ○ No |
| **Are any of the above persons your spouse?** | ○ Yes | ○ No |
| **If yes, should their appointment be void if you become divorced?** | ○ Yes | ○ No |

### b. COMING INTO EFFECT

**Personal Directive becomes effective:**

(i) Upon my becoming mentally incapable of making reasonable judgements in respect of matters relating to my estate; OR
(ii) Becoming physically unable to communicate decisions or judgement

### c. FUNERAL ARRANGEMENTS

| | | |
|---|---|---|
| **Identify any wishes respecting:**<br>cremation vs. burial, disposition of ashes or body (location of cemetery plot, etc.), type of memorial or religious service | | |
| **Include funeral wishes in Personal Directive** | ○ Yes | ○ No |
| **I have made pre-arrangements with a funeral home** | ○ Yes<br>If yes, please provide details: | ○ No |

## d. DETERMINING CAPACITY

**Who can determine if you lack capacity?** (*Select one*)

| | |
|---|---|
| ◯ | Written declaration from two doctors caring for you |
| ◯ | Written declaration from the following person(s): |

| | | FULL LEGAL NAME | RELATIONSHIP | ADDRESS (City, Province, Country) |
|---|---|---|---|---|
| | 1. | | | |
| | 2. | | | |

## e. TREATMENT INSTRUCTIONS (*check all that apply*)

☐ I wish to benefit from life-support procedures only when they are required to sustain me while I recover from a transient illness or trauma with the expectation that I will resume a reasonably independent lifestyle with the ability to recognize family and friends and communicate effectively my wants and needs.

☐ However, these are my directions if I am in a coma or a persistent vegetative state and my physician and other medical consultants have advised that, no matter what is done, I have no reasonable hope of regaining awareness of my surroundings or high mental functions. Indications of this may include my inability to recognize family and friends and to communicate effectively my wants and needs.

☐ a) I wish to be kept comfortable and free from pain. This means that I may be given pain medication, including sufficient analgesics to control pain, moaning, and restlessness, even though it may dull consciousness and indirectly shorten my life.

☐ b) I instruct my health care service providers to refrain from any medical or surgical treatments and procedures, such as:

- electrical or mechanical resuscitation of my heart when it has stopped beating,
- antibiotic therapy
- tube feeding
- surgery
- mechanical respiration when I am no longer able to sustain my own breathing
- and similar treatments and procedures.

☐ My main concern is that I be allowed to die with maximum dignity and with the least pain. I do not fear death itself as much as the indignities of deterioration, dependence and endless pain.

☐ Other wishes: *(while the above appear to be the most common instructions, please describe any other instructions you may have)*

_____
_____
_____
_____

| **f. ORGAN DONATION** (*Select one*) | |
|---|---|
| ○ | Do not include in Personal Directive |
| ○ | Refusal to consent to organ donation |
| ○ | Consent to donate: (*Check all that apply*)<br>**The following organs:**<br>☐ Eyes<br>☐ Internal organs<br>☐ Skin<br>☐ All of the above<br>☐ Others – Please specify: _____<br>_____<br>**For the following purposes:**<br>☐ Transplant<br>☐ Scientific Research<br>☐ Medical Education<br>☐ All of the above<br>☐ Others – Please specify: _____<br>_____ |

**g. TEMPORARY AGENTS FOR MINOR CHILDREN**

*In the event you are unable able to act as guardian and you lack capacity, you appoint the following persons to have the authority for temporary care and education of your minor children.*

| | FULL LEGAL NAME | RELATIONSHIP | AGE | ADDRESS (City, Province, Country) |
|---|---|---|---|---|
| 1. | | | | |
| | **ALTERNATES** | | | |
| 2. | | | | |
| 3. | | | | |

**h. NOTES**