DURABLE POWER OF ATTORNEY for Health Care Decisions (poa130) *Service Invoice*

CUSTOMER INFORMATION
Customer Name: _____ Phone: _____
Email Address: _____
DOCUMENT INFORMATION
Name of Grantor (person **giving** the POA)
Complete Address of Grantor
Appointee/Attorney-in-fact (person **receiving** the POA):
Complete Address of Appointee/Attorney-in-fact:
Phone Number of Appointee/Attorney-in-fact:
Grantor may designate two alternate Appointees in the event the primary Appointee/Attorney-in-fact is unable or unwilling to act as the appointee/attorney-in-fact.
First Alternate Attorney-in-fact:
Complete Address of **First** Alternate:
Phone Number of **First** Alternate Attorney-in-fact:
Second Alternate Attorney-in-fact:
Complete Address of **Second** Alternate:
Phone Number of **Second** Alternate Attorney-in-fact:
Special Instructions: