



Personal Directive Questionnaire

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address & Postal Code: \_\_\_\_\_

Phone/fax/email: \_\_\_\_\_

- 1. Name an agent (this is the person(s) that will make personal decisions for you should you lose the capacity to make them yourself.**

Name of Agent: \_\_\_\_\_

Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

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

- 2. If you want more than one agent to act together (joint agents), name the other agent or agents here:**

Name of Agent: \_\_\_\_\_

Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

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

Name of Agent: \_\_\_\_\_

Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

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



**3. If you are naming more than two agents, do they make decisions on a majority basis or do they all have to agree?**

- On a majority basis
- They all have to agree

**4. If you are not naming joint agents and your first-named agent cannot or will not act, name your second choice here:**

Name of Agent: \_\_\_\_\_

Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

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

**5. If your second named agent cannot or will not act, name your third choice here:**

Name of Agent: \_\_\_\_\_

Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

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

**6. Indicate who should decide whether or not you have lost the capacity to make decisions about any personal matter:**

- One doctor
- Two doctors
- \_\_\_\_\_ together with:  one doctor or  two doctors



Others – Name and Address:

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**7. Do you want to donate your organs and tissue for transplantation purposes if at the time of your death you have any that would be useful for this purpose?**

Yes

No

**8. What are your views about being kept alive artificially if there is no known hope of recovery?**

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Schedule "A" to the Personal Directive  
for \_\_\_\_\_

**Family members and or interested persons whom I want my Agent to notify**

**(Note: Please keep the information on this Schedule up to date)**

**SPOUSE**

Name	
Address	
Phone No.	

**CHILDREN**

Name	
Address	
Phone No.	

Name	
Address	
Phone No.	



# CHRISTOPHER G. TASKEY

— EXPERIENCE, INTEGRITY, RESULTS —

Name	
Address	
Phone No.	

Name	
Address	
Phone No.	

## PHYSICIAN

Name	
Address	
Phone No.	

## DENTIST

Name	
Address	
Phone No.	



**ATTORNEY IN ENDURING POWER OF ATTORNEY**

Name	
Address	
Phone No.	

**LAWYER**

Name	
Address	
Phone No.	

**OTHER INTERESTED PARTIES**

Name and Relationship	
Address	
Phone No.	

Name and Relationship	
Address	
Phone No.	



**Family members and other persons that I direct my Agent NOT to notify**

**(Note: please keep the information on this Schedule up to date)**

Name	
Address	
Phone No.	

Name	
Address	
Phone No.	