MEDICAL POWER OF ATTORNEY

STATE OF WYOMING)
) ss.
COUNTY OF_____)

Know All Men By These Presents that I,_____, residing at _____,_____, Wyoming,_____hereby make, constitute, and appoint,_____my true and lawful attorney in fact for use and in my name, place and stead, and on our behalf and for my use and benefit as follows:

To obtain medical care for whatever reason as required if I am unable to do so for myself for whatever reason._____has the authority to contract with any physician, hospital, or other type of health facility which is necessary to provide for the adequate care of myself,_____.

The above named individual shall have the authority to complete and sign any required documentation, authorizations, or release necessary to obtain the requisite medical care and to otherwise exercise or perform any act, power, duty, right, or obligation whatsoever that I would have or may be required to exercise or perform to obtain the necessary medical care for myself if I am unable to do so for any reason.

The above-named individual shall have the power and authority to do, take, and perform all and every act or thing whatsoever requisite, proper, or necessary to be done in the exercise of any of the rights and powers herein granted as fully to all extent and purpose as I might or could do if I were personally capable with full power of substitution or revocation hereby ratifying and confirming all that said attorney in fact shall lawfully do or cause to be done by virtue of this Power of Attorney and the rights and powers herein granted. This medical Power of Attorney in the enumeration of said specific items, rights, acts, and powers herein is not intended to, nor does it limit or restrict, and is not to be construed or interpreted as limiting or restricting the medical powers herein granted to said attorney in fact.

The rights, powers, and authorities of the said attorney in fact herein granted shall commence on the_____day of_____, 20 , and such rights, powers, and authorities shall remain in full force and effect until revoked in writing. By signing this Medical Power of Attorney I am hereby revoking all previous Medical Power of Attorneys in whatever form they may be and wherever they may be kept.

DATED this_____day of_____, 20___.

_____

WITNESS STATEMENT AND ACKNOWLEDGMENT:

I am not the person appointed as agent or successor agent in this medical power of attorney. I am not related to the maker of this document by blood or marriage. I am not entitled to any portion of the maker's estate, nor do I have any claim against the maker's estate. I am not the attending physician of the maker or an employee of the attending physician. I am not involved in providing direct patient care to the maker and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

SIGNATURE OF FIRST WITNESS

Signature: _____

Print Name: _____ Date: _____

Address: _____

SIGNATURE OF SECOND WITNESS

Signature: _____

Print Name: _____ Date: _____

Address: _____

STATE OF WYOMING)
) ss.
COUNTY OF_____)

SUBSCRIBED AND SWORN to me this_____day of_____, 20___, by_____.

WITNESS my hand and official seal.

_____
Notary Public

My commission expires: