MEDICAL POWER OF ATTORNEY

STATE OF WYOMING

) 88		
) ss. (COUNTY OF)		
Know All Men By These Pre	esents that I,	, residing at
	, Wyoming,	hereby make, constitute,
and appoint,		
my name, place and stead, and on or	•	•
To obtain medical care for wh	natever reason as re	quired if I am unable to do so
for myself for whatever reason		_ has the authority to contract
with any physician, hospital, or oth	ner type of health f	facility which is necessary to
provide for the adequate care of my	self,	·

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, an shall commence on the authorities shall remain in fu this Medical Power of Attorn Attorneys in whatever form t	day of ll force and effect ey I am hereby re	_, 20, and such ri t until revoked in wri voking all previous N	ghts, powers, and iting. By signing Medical Power of
DATED this	day of		,20
STATE OF WYOMING)		
STATE OF WYOMING COUNTY OF) ss.)		
SUBSCRIBED AND SWOR by	RN to me this	day of	, 20,
WITNESS my hand ar	nd official seal.		
No	tary Public		

My commission expires: