Durable Power of Attorney for Health Care or Property -- Supplement©

This supplement includes a forms guide as well as forms. The forms guide is for use only in filling out the forms. For more information about what these forms mean or are used for, consult the appropriate Self Help packet, additional reference materials and the applicable statutes and case law available at the Southern Illinois Law Library or other law library available to you.

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Forms and Notices That Are Included in This Supplement

Notice to the Individual Signing the Illinois Statutory Short Form Power of Attorney for Health Care*
- as provided by 755 ILCS 45/4-10 as amended effective July 1, 2011

Statutory Short Form Power of Attorney for Health Care*
- as provided by 755 ILCS 45/4-10 as amended effective July 1, 2011

Notice to the Individual Signing the Illinois Statutory Short Form Power of Attorney for Property
- as provided by 755 ILCS 45/3-3 as amended effective July 1, 2011

Statutory Short Form Power of Attorney for Property*
- as provided by 755 ILCS 45/3-3 as amended effective July 1, 2011

Notice to Agent*
- as provided by 755 ILCS 45/3-3 as amended effective July 1, 2011

Agent's Certification and Acceptance of Authority*
- to be completed and submitted on request as specified at 755 ILCS 45/2-8 as amended effective July 1, 2011

Successor Agent's Certification and Acceptance of Authority*
- to be completed and submitted on request as specified at 755 ILCS 45/2-10.3 as amended effective July 1, 2011

Resignation of an Agent**

Notice of Revocation of a Durable Power of Attorney**
- see also 755 ILCS 45/2-5 and 755 ILCS 45/4-6 re other methods of revocation

***** **Instructions and explanations** are incorporated within the Statutory Short Form Power of Attorney for Health Care, the Statutory Short Form Power of Attorney for Property, and the related notices provided in this supplement as provided by the Illinois Power of Attorney Act itself. 755 ILCS 45/ *(look for text in italic typeface like this in the forms)*.

The full text of the Act is available without charge online at the Illinois General Assembly Website http://www.ilga.gov/legislation/ilcs/ilcs.asp by scrolling down to Chapter 755, selecting the link to the Act at 755 ILCS 45/, then either choosing to "View Entire Act" or selecting from the available links to the individual portions or "Articles" of interest, including Article III, Powers of Attorney for Property, and Article IV, Powers of Attorney for Health Care.

** **Instructions for these two forms are provided below.**

Resignation of an Agent

I:	Put in your full name.
Of:	Put in your street address.
City:	Put in the name of your city.
County:	Put in your county.

State: Put in Illinois.
Created by: Put in the principal=s name.
Date: Put in the date the Durable Power of Attorney was created.
Effective: Put in the date you want the resignation to take effect.
Date2: Put in the date you completed the resignation.
Signature: Sign your full name.
Notary: Have the form notarized.

Notice of Revocation of a Durable Power of Attorney

I: Put in your full name.
Of: Put in your street address.
City: Put in the name of your city.
County: Put in your county.
State: Put in Illinois.
DPOA: Keep the type of power that you previously created. Strike out the other.
Created by: Put in the principal's name.
Date: Put in the date the Durable Power of Attorney was created.
Empowering: Put in your agent's full name.
DPOA: Keep the type of power that you previously created. Strike out the other.
Date2: Put in the date you completed the notice of revocation.
Signature: Sign your full name.
Notary: Have the form notarized.

RESET FORM HIGHLIGHT FIELDS PRINT FORM

NOTICE TO THE INDIVIDUAL SIGNING THE ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE

PLEASE READ THIS NOTICE CAREFULLY. The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. 755 ILCS 45/. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

The purpose of this Power of Attorney is to give your designated "agent" broad powers to make health care decisions for you, including the power to require, consent to, or withdraw treatment for any physical or mental condition, and to admit you or discharge you from any hospital, home, or other institution. You may name successor agents under this form, but you may not name co-agents.

This form does not impose a duty upon your agent to make such health care decisions, so it is important that you select an agent who will agree to do this for you and who will make those decisions as you would wish. It is also important to select an agent whom you trust, since you are giving that agent control over your medical decision-making, including end-of-life decisions. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she must also act in accordance with the law and with the statements in this form. Your agent must keep a record of all significant actions taken as your agent.

Unless you specifically limit the period of time that this Power of Attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, even after you become disabled. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You may also revoke this Power of Attorney if you wish.

The Powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, and 4-10(b) of the Illinois Power of Attorney Act. This form is a part of that law. *The "NOTE" paragraphs throughout this form are instructions.*

You are not required to sign this Power of Attorney, but it will not take effect without your signature. You should not sign it if you do not understand everything in it, and what your agent will be able to do if you do sign it.

Please put your initials on the following line indicating that you have read this Notice:

_____
(Principal's initials)

ILLINOIS STATUTORY SHORT FORM
POWER OF ATTORNEY FOR HEALTH CARE

1. I, _____ *(insert full name and address of principal)* hereby revoke all prior powers of attorney for health care executed by me and appoint: _____ *(insert full name and address of agent)*

(NOTE: You may not name co-agents using this form)

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.

A. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

B. Effective upon my death, my agent has the full power to make an anatomical gift of the following:

(NOTE: Initial and thereby select one of the following three options. IN THE EVENT NONE OF THE OPTIONS ARE INITIALED, THEN IT SHALL BE CONCLUDED THAT YOU DO NOT WISH TO GRANT YOUR AGENT ANY SUCH AUTHORITY.)

____ Any organs, tissues, or eyes suitable for transplantation or used for research or education.
____ Specific organs listed here:_____
____ I do not grant my agent authority to make any anatomical gifts.

C. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act, 755 ILCS 65/1 et seq.. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.

D. I intend for the person named as my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder. I intend for the person named as my agent to serve as my "personal representative" as that term is defined under HIPAA and regulations thereunder.

(i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties.

(ii) I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Informational Bureau, Inc., or any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to give, disclose, and release to the person named as my agent, without restriction, all of my individually identifiable

health information and medical records, regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act).

(iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. The authority given to the person named as my agent to serve as my "personal representative" as defined under HIPAA and regulations thereunder and to access my individually identifiable health information or authorize the release of the same to third parties shall take effect immediately, even if I designate in Paragraph 3 of this document that this agency shall otherwise take effect at some future date.

(NOTE: The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

(NOTE: Here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.)

_____
_____
_____
_____
_____
_____

(NOTE: The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but do not initial more than one. These statements serve as guidance for your agent, who shall give careful consideration to the statement you initial when engaging in health care decision-making on your behalf.)

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued, unless I am, in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of "permanent unconsciousness" or suffer from an "incurable or irreversible condition" or "terminal condition", as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in any one of these states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed _____

(NOTE: This power of attorney may be amended or revoked by you in the manner provided in Section 4-6 of the Illinois Power of Attorney Act. Your agent can act immediately, unless you specify otherwise; but you cannot specify otherwise with respect to your "personal representative" under subparagraph D(iii).)

3. This power of attorney shall become effective on _____
_____

(NOTE: Insert a future date or event during your lifetime, such as a court determination of your disability or a written determination by your physician that you are incapacitated, when you want this power to first take effect.)

(NOTE: If you do not amend or revoke this power, or if you do not specify a specific ending date in paragraph 4, it will remain in effect until your death; except that your agent will still have the authority to donate your organs, authorize an autopsy, and dispose of your remains after your death, if you grant that authority to your agent.)

4. This power of attorney shall terminate on _____
_____

(NOTE: Insert a future date or event, such as a court determination that you are not under a legal disability or a written determination by your physician that you are not incapacitated, if you want this power to terminate prior to your death.)

(NOTE: You cannot use this form to name co-agents. If you wish to name successor agents, insert the names and addresses of the successors in paragraph 5.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

_____
_____

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor, or an adjudicated incompetent or disabled person, or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(NOTE: If you wish to, you may name your agent as guardian of your person if a court decides that one should be appointed. To do this, retain paragraph 6, and the court will appoint your agent if the court finds that this appointment will serve your best interests and welfare. <u>Strike out paragraph 6 if you do not want your agent to act as guardian</u>.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Dated: _____

Signed _____
(Principal's signature or mark)

The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

_____
(Witness signature)

_____
(Print witness name)

_____
(Street address)

_____
(City, State, ZIP)

(NOTE: You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)

Specimen signatures of agent (and successors).	I certify that the signatures of my agent (and successors) are correct.
_____ (Agent)	_____ (Principal)
_____ (Successor Agent)	_____ (Principal)
_____ (Successor Agent)	_____ (Principal)

(NOTE: The name, address, and phone number of the person preparing this form or who assisted the principal in completing this form <u>is optional</u>.)

_____
(Name of preparer)

_____
(Street address)

_____
(City, State, ZIP)

_____
(Phone)

NOTICE TO THE INDIVIDUAL SIGNING THE ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR PROPERTY

PLEASE READ THIS NOTICE CAREFULLY. The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. 755 ILCS 45/. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

The purpose of this Power of Attorney is to give your designated "agent" broad powers to handle your financial affairs, which may include the power to pledge, sell, or dispose of any of your real or personal property, even without your consent or any advance notice to you. When using the Statutory Short Form, you may name successor agents, but you may not name co-agents.

This form does not impose a duty upon your agent to handle your financial affairs, so it is important that you select an agent who will agree to do this for you. It is also important to select an agent whom you trust, since you are giving that agent control over your financial assets and property. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she must also act in accordance with the law and with the directions in this form. Your agent must keep a record of all receipts, disbursements, and significant actions taken as your agent.

Unless you specifically limit the period of time that this Power of Attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, both before and after you become incapacitated. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You may also revoke this Power of Attorney if you wish.

This Power of Attorney does not authorize your agent to appear in court for you as an attorney-at-law or otherwise to engage in the practice of law unless he or she is a licensed attorney who is authorized to practice law in Illinois.

The powers you give your agent are explained more fully in Section 3-4 of the Illinois Power of Attorney Act. This form is a part of that law. *The "NOTE" paragraphs throughout this form are instructions.*

You are not required to sign this Power of Attorney, but it will not take effect without your signature. You should not sign this Power of Attorney if you do not understand everything in it, and what your agent will be able to do if you do sign it.

Please put your initials on the following line indicating that you have read this Notice:

_____
Principal's initials

ILLINOIS STATUTORY SHORT FORM
POWER OF ATTORNEY FOR PROPERTY

1. I, _____ *(insert name and address of principal)* hereby revoke all prior powers of attorney for property executed by me and appoint: _____ *(insert name and address of agent)*

(NOTE: You may not name co-agents using this form)

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) with respect to the following powers, as defined in Section 3-4 of the "Statutory Short Form Power of Attorney for Property Law" (including all amendments), but subject to any limitations on or additions to the specified powers inserted in paragraph 2 or 3 below:

(NOTE: You must strike out any one or more of the following categories of powers you do not want your agent to have. Failure to strike the title of any category will cause the powers described in that category to be granted to the agent. To strike out a category you must draw a line through the title of that category.)

(a) Real estate transactions.

(b) Financial institution transactions.

(c) Stock and bond transactions.

(d) Tangible personal property transactions.

(e) Safe deposit box transactions.

(f) Insurance and annuity transactions.

(g) Retirement plan transactions.

(h) Social Security, employment and military service benefits.

(i) Tax matters.

(j) Claims and litigation.

(k) Commodity and option transactions.

(l) Business operations.

(m) Borrowing transactions.

(n) Estate transactions.

(o) All other property transactions.

(NOTE: Limitations on and additions to the agent's powers may be included in this power of attorney if they are specifically described below.)

2. The powers granted above shall not include the following powers or shall be modified or limited in the following particulars:

(NOTE: Here you may include any specific limitations you deem appropriate, such as a prohibition or conditions on the sale of particular stock or real estate or special rules on borrowing by the agent.)

_____
_____
_____
_____
_____
_____
_____
_____

3. In addition to the powers granted above, I grant my agent the following powers:

(NOTE: Here you may add any other delegable powers including, without limitation, power to make gifts, exercise powers of appointment, name or change beneficiaries or joint tenants or revoke or amend any trust specifically referred to below.)

_____
_____
_____
_____
_____
_____
_____

(NOTE: Your agent will have authority to employ other persons as necessary to enable the agent to properly exercise the powers granted in this form, but your agent will have to make all discretionary decisions. If you <u>want</u> to give your agent the right to delegate discretionary decision-making powers to others, you should <u>keep</u> paragraph 4, <u>otherwise it should be struck out</u>.)

4. My agent shall have the right by written instrument to delegate any or all of the foregoing powers involving discretionary decision-making to any person or persons whom my agent may select, but such delegation may be amended or revoked by any agent (including any successor) named by me who is acting under this power of attorney at the time of reference.

(NOTE: Your agent will be entitled to reimbursement for all reasonable expenses incurred in acting under this power of attorney. <u>Strike out</u> paragraph 5 if you do <u>not</u> want your agent to <u>also</u> be entitled to reasonable compensation for services as agent.)

5. My agent shall be entitled to reasonable compensation for services rendered as agent under this power of attorney.

(NOTE: This power of attorney may be amended or revoked by you at any time and in any manner. Absent amendment or revocation, the authority granted in this power of attorney will become effective at the time this power is signed and will continue until your death, unless a limitation on the beginning date or duration is made by initialing <u>and</u> completing one or both of paragraphs 6 and 7.)

6. _____*(Initial if stating a beginning date other than at signing and then complete the following)* This power of attorney shall become effective on _____
_____

(NOTE: Insert a future date or event during your lifetime, such as a court determination of your disability or a written determination by your physician that you are incapacitated, when you want this power to first take effect.)

7. _____*(Initial if stating a duration date other than until your death and then complete the following)* This power of attorney shall terminate on _____
_____

(NOTE: Insert a future date or event, such as a court determination that you are not under a legal disability or a written determination by your physician that you are not incapacitated, if you want this power to terminate prior to your death.)

8. If any agent named by me shall die, become incompetent, resign or refuse to accept the office of agent, I name the following (each to act alone and successively, in the order named) as successor(s) to such agent:
_____
_____

(NOTE: If you wish to name one or more successor agents, insert the name and address of each successor agent in paragraph 8.)

For purposes of this paragraph 8, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to business matters, as certified by a licensed physician.

(NOTE: If you wish to, you may name your agent as guardian of your estate if a court decides that one should be appointed. To do this, retain paragraph 9, and the court will appoint your agent if the court finds that this appointment will serve your best interests and welfare. Strike out paragraph 9 if you do not want your agent to act as guardian.)

9. If a guardian of my estate (my property) is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

10. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

(NOTE: This form does not authorize your agent to appear in court for you as an attorney-at-law or otherwise to engage in the practice of law unless he or she is a licensed attorney who is authorized to practice law in Illinois.)

11. The Notice to Agent is incorporated by reference and included as part of this form.

Dated: _____

Signed _____
(Principal)

(NOTE: This power of attorney will not be effective unless it is signed by at least one witness and your signature is notarized, using the form below. The notary may not also sign as a witness.)

The undersigned witness certifies that _____, known to me to be the same person whose name is subscribed as principal to the foregoing power of attorney, appeared before me and the notary public and acknowledged signing and delivering the instrument as the free and voluntary act of the principal, for the uses and purposes therein set forth. I believe him or her to be of sound mind and memory. The undersigned

witness also certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

Dated: _____

_____
(Witness signature)

(NOTE: Illinois requires only one witness, but other jurisdictions may require more than one witness. If you wish to have a second witness, have him or her certify and sign here:)

(Second witness) The undersigned witness certifies that _____, known to me to be the same person whose name is subscribed as principal to the foregoing power of attorney, appeared before me and the notary public and acknowledged signing and delivering the instrument as the free and voluntary act of the principal, for the uses and purposes therein set forth. I believe him or her to be of sound mind and memory. The undersigned witness also certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

Dated: _____

_____
(Witness signature)

State of _____)
) SS.
County of _____)

The undersigned, a notary public in and for the above county and state, certifies that _____ _____, known to me to be the same person whose name is subscribed as principal to the foregoing power of attorney, appeared before me and the witness(es) _____(and _____) in person and acknowledged signing and delivering the instrument as the free and voluntary act of the principal, for the uses and purposes therein set forth, and certified to the correctness of the signature(s) of the agent(s).

Dated: _____

_____
(Notary Public)

My commission expires _____

(NOTE: You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)

Specimen signatures of agent (and successors).	I certify that the signatures of my agent (and successors) are correct.
_____	_____
(Agent)	(Principal)
_____	_____
(Successor Agent)	(Principal)
_____	_____
(Successor Agent)	(Principal)

(NOTE: The name, address, and phone number of the person preparing this form or who assisted the principal in completing this form should be inserted below.)

_____
(Name of preparer)

_____
(Street address)

_____
(City, State, ZIP)

_____
(Phone)

The following form may be known as "Notice to Agent" and shall be supplied to an agent appointed under a power of attorney for property. 755 ILCS 45/3-3(e).

NOTICE TO AGENT

When you accept the authority granted under this power of attorney a special legal relationship, known as agency, is created between you and the principal. Agency imposes upon you duties that continue until you resign or the power of attorney is terminated or revoked.

As agent you must:

(1) do what you know the principal reasonably expects you to do with the principal's property;

(2) act in good faith for the best interest of the principal, using due care, competence, and diligence;

(3) keep a complete and detailed record of all receipts, disbursements, and significant actions conducted for the principal;

(4) attempt to preserve the principal's estate plan, to the extent actually known by the agent, if preserving the plan is consistent with the principal's best interest; and

(5) cooperate with a person who has authority to make health care decisions for the principal to carry out the principal's reasonable expectations to the extent actually in the principal's best interest

As agent you must not do any of the following:

(1) act so as to create a conflict of interest that is inconsistent with the other principles in this Notice to Agent;

(2) do any act beyond the authority granted in this power of attorney;

(3) commingle the principal's funds with your funds;

(4) borrow funds or other property from the principal, unless otherwise authorized;

(5) continue acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney, such as the death of the principal, your legal separation from the principal, or the dissolution of your marriage to the principal.

If you have special skills or expertise, you must use those special skills and expertise when acting for the principal.

You must disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name "as Agent" in the following manner:

"(Principal's Name) by (Your Name) as Agent"

The meaning of the powers granted to you is contained in Section 3-4 of the Illinois Power of Attorney Act, which is incorporated by reference into the body of the power of attorney for property document.

If you violate your duties as agent or act outside the authority granted to you, you may be liable for any damages, including attorney's fees and costs, caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice from an attorney.

AGENT'S CERTIFICATION AND ACCEPTANCE OF AUTHORITY

I, _____*(insert name of agent)*, certify that the attached is a true copy of a power of attorney naming the undersigned as agent or successor agent for _____ *(insert name of principal)*.

I certify that to the best of my knowledge the principal had the capacity to execute the power of attorney, is alive, and has not revoked the power of attorney; that my powers as agent have not been altered or terminated; and that the power of attorney remains in full force and effect.

I accept appointment as agent under this power of attorney.

This certification and acceptance is made under penalty of perjury.*

Dated: _____

_____
(Agent's Signature)

_____
(Print Agent's Name)

_____
(Agent's Address)

*(NOTE: Perjury is defined in Section 32‑2 of the Criminal Code of 1961, and is a Class 3 felony.)

SUCCESSOR AGENT'S
CERTIFICATION AND ACCEPTANCE OF AUTHORITY

I certify that the attached is a true copy of a power of attorney naming the undersigned as agent or successor agent for _____ *(insert name of principal)*.

I certify that to the best of my knowledge the principal had the capacity to execute the power of attorney, is alive, and has not revoked the power of attorney; that my powers as agent have not been altered or terminated; and that the power of attorney remains in full force and effect.

I certify that to the best of my knowledge _____ *(insert name of unavailable agent*) is unavailable due to _____ *(specify death, resignation, absence, illness, or other temporary incapacity)*.

I accept appointment as agent under this power of attorney.

This certification and acceptance is made under penalty of perjury.*

Dated: _____

_____
(Agent's Signature)

_____
(Print Agent's Name)

_____
(Agent's Address)

*(NOTE: Perjury is defined in Section 32-2 of the Criminal Code of 1961, and is a Class 3 felony.)

RESIGNATION OF AGENT

I, _____, of _____,
City of _____, County of _____,
State of _____, resign as agent under the Power of Attorney for (Property)
(Health Care) created by _____ and dated _____.
My resignation is effective _____.

Dated: _____

_____
(Signature of Agent)

State of _____)
) ss.
County of _____)

On this _____ day of _____, _____, before me, _____ ,a notary public in said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that she/he executed the same in her/his authorized capacity, and that by her/his signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.
WITNESS my hand and official seal.

_____
Notary Public for the State of _____

[notarial seal] My commission expires:_____

NOTICE OF REVOCATION OF DURABLE POWER OF ATTORNEY

I, _____, of _____,
City of _____, County of _____,
State of _____, revoke the Durable/Statutory Short Form Power of Attorney for (Property) (HealthCare) dated _____, empowering _____ to act as my agent. I revoke and withdraw all power and authority granted under that Durable/Statutory Short Form Power of Attorney for Property) (Health Care).

Dated: _____

_____
(Signature of Principal)

State of _____)
) ss.
County of _____)

On this _____ day of _____, _____, before me, _____, a notary public in said state, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that she/he executed the same in her/his authorized capacity, and that by her/his signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.
WITNESS my hand and official seal.

_____
Notary Public for the State of _____

[notarial seal] My commission expires:_____

RESET FORM HIGHLIGHT FIELDS PRINT FORM