

**UTAH LEGAL CLINIC**  
214 East Fifth South Street  
Salt Lake City, Utah 84111-3204  
(801) 328-9531

Attorney  
Brian M. Barnard  
Stewart W. Gollan

Fax Number  
(801) 328-9533

**WILL INTAKE FORM**

*Please fill out the following information prior to your appointment with our office. We will use this information to draft a Simple Will (distributing your assets, setting out burial requests, guardian for minor children, etc.), a Medical and Financial Power of Attorney (selecting someone to make medical and financial decisions for you in the event you are unable to do so yourself), and a Living Will/Advanced Health Care Directive (electing or declining life-prolonging heroic measures).*

**PERSONAL INFORMATION:**

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

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

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Children's Names and City of Residence (please include date of birth if the child is a minor):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AGENT INFORMATION:**

*This person follows your instructions and makes sure your wishes are followed.*

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

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

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ALTERNATE AGENT INFORMATION:**

*This person will serve as your agent if your agent, named above, is unable or unwilling to serve.*

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

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

City: \_\_\_\_\_ State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

YES  NO I would like to authorize my agent to get copies of my medical records at any time, even when I can speak for myself.

YES  NO I would like to authorize my agent to admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

YES  NO I would like to place the limits or expansions on the powers of my health care agent. *(Specify below.)*

Limits/Expansions: \_\_\_\_\_

YES  NO I would like to authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

YES  NO If I have not otherwise agreed to organ donation, I would like to authorize my agent to consent to the donation of my organs for the purpose of organ transplantation.

YES  NO I would like to nominate my agent or alternate agent to serve as my guardian in the event that I become incapacitated. *Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary.*

**IF THERE ARE NO MINOR CHILDREN, SKIP THE NEXT PAGE  
AND CONTINUE ON PAGE 4.**

**MINOR CHILD(REN) INFORMATION:**

**TRUSTEE/CONSERVATOR:** *This person manages money on behalf of your minor children.*

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_

**ALTERNATE TRUSTEE/CONSERVATOR:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_

**GUARDIAN:** *This person physically cares for your minor children.*

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_

**ALTERNATE GUARDIAN:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_



**LIVING WILL (ADVANCE HEALTH CARE DIRECTIVE) INFORMATION:**

*A living will gives instructions to doctors and family members in the event you are terminally ill and unable to speak for yourself. A living will sets out your wishes with regard to life sustaining equipment and/or heroic action being used to prolong your life.*

*Please select ONE option from the following.*

If at any time I should have an injury, disease, or illness, which is certified in writing to be a terminal condition or persistent vegetative state by two (2) physicians who have personally examined me, and in the opinion of those physicians the application of life-sustaining procedures would serve only to unnaturally prolong the moment of my death and to unnaturally postpone or prolong the dying process,

- OPTION 1: I choose to let my agent decide.
- OPTION 2: I choose to prolong life.
- OPTION 3: I choose not to receive care for the purpose of prolonging life.

*If Option 3 is selected, please select either (A) or (B):*

- (A) I put no limit on the ability of my health care provider or agent to withhold or withdraw life sustaining care.
- (B) My health care provider should withhold or withdraw life-sustaining care if at least one of the following conditions is met (check all that apply):

- \_\_\_\_\_ I have a progressive illness that will cause death.
- \_\_\_\_\_ I am close to death and am unlikely to recover.
- \_\_\_\_\_ I cannot communicate and it is unlikely that my condition will improve.
- \_\_\_\_\_ I do not recognize my family or friends and it is unlikely that my condition will improve.
- \_\_\_\_\_ I am in a persistent vegetative state.

**ADDITIONAL INSTRUCTIONS:**

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**PLEASE READ THE FOLLOWING**

Your appointment today is to discuss our office drafting a Will, a Living Will, and a Medical and Financial Special Power of Attorney. The fee we charge for drafting those three (3) documents is \$125.00.

Based upon the information that you have given us, we will draft a Will, a Living Will, and the Power of Attorney. We will mail those documents to you for review. You should receive those in the mail from us within fourteen (14) days of this appointment. If you do not receive them within that time, please call our office and ask when the documents will be completed.

After you have received and reviewed the documents, if there are changes necessary or if you have questions, please call our office. If the documents are correct and complete, please call our office and set an appointment to come in and sign your Wills. You must sign before a Notary Public and two (2) witnesses. Staff members in our office will serve as the Notary Public and as witnesses. Your appointment to sign the Wills will take at least twenty (20) minutes at our office.

After you have signed the final documents, we recommend that you keep the original documents in a safe place (a bank safety deposit box, etc.) that you and your Agent both have access to or have knowledge of. You should give copies of your Living Will and Medical Power of Attorney to your physician and relatives so that they know your wishes. Although we will keep a photocopy of these documents, you have the only signed valid formal originals. If you want to make changes in these documents in the future, you should consult an attorney to do so.

The policy of our office is to collect the fee and write you a receipt when you have completed this form, read this agreement, and before you talk to the attorney.

If you have any questions about this agreement, please ask one of our staff members before you sign.

**I HAVE READ AND UNDERSTAND THE FOREGOING AGREEMENT AND AGREE TO THE TERMS OF THIS AGREEMENT. ALL OF THE INFORMATION AS SET FORTH ABOVE AND PROVIDED BY ME (THE CLIENT) IS TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLIENT SIGNATURE

cc: Client (this page only)

UTAH LEGAL CLINIC  
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Salt Lake City, Utah 84111-3204  
(801) 328-9531

**\*\*CLIENT COPY\*\***

Your appointment today is to discuss our office drafting a Will, a Living Will, Medical Special Power of Attorney, and Financial Special Power of Attorney. The fee we charge for drafting those four (4) documents is \$125.00.

Based upon the information that you have given us, we will draft a Will, a Living Will, and two (2) Special Powers of Attorney. We will mail those documents to you for review. You should receive those in the mail from us within fourteen (14) days of this appointment. If you do not receive them within that time, please call our office and ask when the documents will be completed.

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XXXXXXXXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

\_\_\_\_\_  
DATE

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CLIENT SIGNATURE

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