

**FINANCIAL POWER OF ATTORNEY**

**WARNING TO PERSON SIGNING THIS DOCUMENT:**

This is an important document. Before signing it, you should be confident that the person you have selected as your attorney-in-fact will act in your interest and will manage your property in a trustworthy manner.

This document does not take effect until a doctor certifies that you are disabled. It ceases to be in effect when you are no longer disabled. You may revoke it at any time you are not disabled.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

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I, \_\_\_\_\_ *[printed name]*, of \_\_\_\_\_ County, Tennessee, appoint \_\_\_\_\_ *[printed name]* to act as my attorney-in-fact regarding all property belonging to me at the time of my disability. In the event the person I appoint is unable, unwilling, or unavailable to act as my attorney-in-fact, I appoint \_\_\_\_\_ *[printed name]*.

I authorize my attorney-in-fact to exercise any and all powers set forth in Tennessee Code Annotated Section 34-6-109. All of its provisions and powers are incorporated herein by reference as fully as if they were copied here verbatim.

Upon my death, the attorney-in-fact shall pay and deliver all assets and any undistributed income owned by me to the person administering my estate.

**This Durable Power of Attorney for Financial Affairs shall become effective only upon my disability.** My disability shall be deemed sufficient to cause this instrument to become effective only at the time that a physician selected in good faith by my attorney-in-fact determines that I am disabled and thus unable to handle my affairs or make financial decisions for myself. Upon receipt of the physician's certificate of my disability, this power of attorney shall take effect.

I nominate my attorney-in-fact to act as my conservator in the event that judicial proceedings involving my person or my estate are ever commenced, and in which the court decides that I am in need of a conservator.

This instrument, once effective, shall continue in force during any mental or physical disability of mine. **However, this document shall cease to be effective when I am no longer disabled.**

**Further, I reserve the right to revoke this appointment at any time when I am not disabled.** This right of revocation is reserved for me alone and not for any guardian, conservator, or any other personal or legal representative of mine. Revocation shall be accomplished by an instrument in writing under my hand delivered to my attorney-in-fact revoking this instrument in whole or in part, or amending and changing the provisions and limitations thereof in such manner as I alone shall see fit. The revocation may also be accomplished by recording a Revocation of Power of Attorney, properly acknowledged by me, in the Register's Office of the county shown above.

**A copy of this document, certified by a notary public or a government official as a true copy, shall have the same effect as the original.**

I am signing my name to this Durable Power of Attorney for Financial Affairs on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

STATE OF TENNESSEE COUNTY OF \_\_\_\_\_

On this the \_\_\_\_\_ day of \_\_\_\_\_, in the year 20\_\_\_\_, before me, the undersigned notary public, personally appeared the person who is named above, who is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_

**CERTIFICATE OF PHYSICIAN ABOUT DISABILITY**

*[A copy of this certificate may be used on each occasion when a physician is asked to determine whether a person is disabled or no longer disabled.]*

I am a physician licensed to practice medicine in the State of Tennessee, certify that I have examined \_\_\_\_\_ and determined her or him to be:  
*[specify one of the choices below with a checkmark or other sign]*

- disabled and thus unable to transact affairs in her or his own behalf or make decisions for herself or himself.
- able to transact affairs in her or his own behalf or make decisions for herself or himself, and thus not disabled.

\_\_\_\_\_  
**SIGNATURE OF PHYSICIAN**

\_\_\_\_\_  
**PRINTED NAME OF PHYSICIAN**

Dated: \_\_\_\_\_, 20\_\_\_\_