

Douglass & Associates Co., LPA
4725 Grayton Road
Cleveland, Ohio 44135
216-362-7777
www.douglasslaw.com

WILL WORKSHEET

Please Print

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE NUMBER Day _____ Evening _____

Date of Birth _____ Social Security No. _____

Spouse _____ Former Spouse's/Partner Name _____

Child Name _____ Date of Birth _____

Address _____

Child Name _____ Date of Birth _____

Address _____

Child Name _____ Date of Birth _____

Address _____

Do you currently have a Last Will and Testament? _____

Administration of Estate

The **Executor or Executrix** is the person who makes sure your Will is properly administered and handled in accordance with your wishes and State law. Select a person you trust to handle your financial affairs.

First Choice:

Name _____ Relationship to you _____

Address _____

City/State/Zip _____

Telephone Number _____

Alternate:

Name _____ Relationship to you _____

Address _____

City/State/Zip _____

Telephone Number Home (_____) Work (_____)

Do you want to require a Bond for your Executor/Executrix? Yes _____ No _____

Have you asked this person if he/she is willing to serve as your Executor/Executrix? ___ Yes ___ No

A **Guardian** is the person who will take care of your minor child/children if both parents die before your children reach 18 years of age.

First Choice:

Name _____ Relationship to you _____
Address _____ City/State _____ Zip _____
Telephone Number _____

Alternate:

Name _____ Relationship to you _____
Address _____ City/State _____ Zip _____
Telephone Number _____

Have you asked this person if he or she is willing to serve as Guardian of your children? ___ Yes ___ No

At what age would you want your children to receive your bequest for them?
18 _____ 21 _____ 25 _____ Other _____

Do you want to provide for your children's education beyond high school? ___ Yes ___ No

Distribution of your Estate

Who do you want to receive your (entire) estate? _____

Do you want Reciprocal Wills for Husband and Wife (husband leaves all to wife; Wife leaves all to Husband) ___ Yes ___ No

Do you want equal distribution among any children ___ Yes ___ No

Do you wish to make **specific bequests** of personal property such as:

- Jewelry _____
- Family heirlooms _____
- Car/boat _____
- Stocks _____
- Other _____

Do you wish to make specific bequests to:

- Church _____
- School _____
- Charity _____
- Other people or institutions _____

If all of your immediate family predeceases you, how do you want your estate distributed?

- Brothers/Sisters _____
- Parents/Parents-in-Law _____
- Grandchildren _____
- Friends _____
- Other Relatives _____

Do you wish to have a **Living Will**?

A **Living Will** is a document that allows you to direct the medical care you would receive if you were to become terminally ill and unable to make your wishes known or become permanently unconscious. If you should be terminally ill and unable to tell your physician or family what you want done, by having completed a **Living Will** you could make certain that your wishes would be followed regarding the medical care you receive.

If you would like a **Living Will** prepared please provide the following:

First person to be contacted:

Name _____ Relationship to you _____
Address _____ City/State _____ Zip _____
Telephone No. (_____) _____

Second person to be contacted:

Name _____ Relationship to you _____
Address _____ City/State _____ Zip _____
Telephone No. (_____) _____

Do you wish to have a **Durable Power of Attorney for Health Care**?

The **Durable Power of Attorney for Health Care** names a person to act as your attorney-in-fact to make health care decisions for you if you become unable to make them for yourself. This person has the power to authorize and refuse medical treatment for you. The power is not limited to situations in which you are terminally ill or permanently unconscious, but generally includes all medical treatment decisions. However, this power is only effective if you are not competent or able to make health care decisions for yourself.

This Durable Power of Attorney for Health Care goes into effect when your attending physician is told about it. It is not necessary to go through any court procedure.

If you would like a **Durable Power of Attorney for Health Care**, please provide the following information:

Designate the Attorney in Fact

Name _____ Relationship to you _____
Address _____ City/State _____ Zip _____
Telephone No. _____

First Alternate:

Name _____ Relationship to you _____
Address _____ City/State _____ Zip _____
Telephone No. (_____) _____

Second Alternate:

Name _____ Relationship to you _____
Address _____ City/State _____ Zip _____
Telephone No. _____