New Mexico Statutory Power of Attorney

NOTICE: THIS IS AN IMPORTANT DOCUMENT. THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT, CHAPTER 45, ARTICLE 5, PART 6 NMSA 1978. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, YOU SHOULD ASK A LAWYER TO EXPLAIN THEM TO YOU. THIS FORM DOES NOT PROHIBIT THE USE OF ANY OTHER FORM. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I, _____ (Name) reside at _____, (Address) New Mexico.

I appoint _____ (Name(s) and address(es)) to serve as my attorney(s)-in-fact.

If any attorney-in-fact appointed above is unable to serve, then I appoint _____ to serve as successor attorney-in-fact in place of the person who is unable to serve.

This power of attorney shall not be affected by my incapacity but will terminate upon my death unless I have revoked it prior to my death. I intend by this power of attorney to avoid a court-supervised guardianship or conservatorship.

Should my attempt be defeated, I ask that my agent be appointed as guardian or conservator of my person or estate.

STRIKE THROUGH THE SENTENCE ABOVE IF YOU DO NOT WANT TO NOMINATE YOUR AGENT AS YOUR GUARDIAN OR CONSERVATOR.

CHECK AND INITIAL THE FOLLOWING PARAGRAPH ONLY IF YOU WANT YOUR ATTORNEY(S)-IN-FACT TO BE ABLE TO ACT ALONE AND INDEPENDENTLY OF EACH OTHER. IF YOU DO NOT CHECK AND INITIAL THE FOLLOWING PARAGRAPH AND MORE THAN ONE PERSON IS NAMED TO ACT ON YOUR BEHALF THEN THEY MUST ACT JOINTLY.

( ) _____ If more than one person is appointed to serve as my attorney-in-fact then they may act severally, alone and independently of each other.

My attorney(s)-in-fact shall have the power to act in my name, place and stead in any way which I myself could do with respect to the following matters to the extent permitted by law:

INITIAL IN THE BOX IN FRONT OF EACH AUTHORIZATION WHICH YOU DESIRE TO GIVE TO YOUR ATTORNEY(S)-IN-FACT. YOUR ATTORNEY(S)-IN-FACT SHALL BE AUTHORIZED TO ENGAGE ONLY IN THOSE ACTIVITIES WHICH ARE INITIALED.

INITIAL
(____) 1. real estate transactions.
(____) 2. stock and bond transactions.

(____) 3. commodity and option transactions.
(____) 4. tangible personal property transactions.
(____) 5. banking and other financial institution transactions.
(____) 6. business operating transactions.
(____) 7. insurance and annuity transactions.
(____) 8. estate, trust and other beneficiary transactions.
(____) 9. claims and litigation.
(____) 10. personal and family maintenance.
(____) 11. benefits from Social Security, Medicare, Medicaid or other government programs or civil or military service.
(____) 12. retirement plan transactions.
(____) 13. tax matters, including any transactions with the Internal Revenue Service.
(____) 14. decisions regarding lifesaving and life prolonging medical treatment.
(____) 15. decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, institutionalization in a nursing home or other facility and home health care.
(____) 16. transfer of property or income as a gift to the principal's spouse for the purpose of qualifying the principal for governmental medical assistance.
(____) 17. ALL OF THE ABOVE POWERS, INCLUDING FINANCIAL AND HEALTH CARE DECISIONS. IF YOU INITIAL THE BOX IN FRONT OF LINE 17, YOU NEED NOT INITIAL ANY OTHER LINES.

SPECIAL INSTRUCTIONS: ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS YOU HAVE GRANTED TO YOUR AGENT.

_____
_____
_____
_____
_____
_____
_____
_____

CHECK AND INITIAL THE FOLLOWING PARAGRAPH IF YOU INTEND FOR THIS POWER OF ATTORNEY TO BECOME EFFECTIVE ONLY IF YOU BECOME INCAPACITATED. YOUR FAILURE TO DO SO WILL MEAN THAT YOUR ATTORNEY(S)-IN-FACT ARE EMPOWERED TO ACT ON YOUR BEHALF FROM THE TIME YOU SIGN THIS DOCUMENT UNTIL YOUR DEATH UNLESS YOU REVOKE THE POWER BEFORE YOUR DEATH.

( ) _____ This power of attorney shall become effective only if I become incapacitated. My attorney(s)-in-fact shall be entitled to rely on notarized statements from two qualified health care professionals, one of whom shall be a physician, as to my incapacity. By incapacity I mean that

among other things, I am unable to effectively manage my personal care, property or financial affairs.

This power of attorney will not be affected by lapse of time. I agree that any third party who receives a copy of this power of attorney may act under it.

_____
(Signature)

_____
(Optional, but preferred: Your social security number)
Dated: _____, 20_____

ACKNOWLEDGEMENT

NOTICE: IF THIS POWER OF ATTORNEY AFFECTS REAL ESTATE, IT MUST BE RECORDED IN THE OFFICE OF THE COUNTY CLERK IN EACH COUNTY WHERE THE REAL ESTATE IS LOCATED.

STATE OF NEW MEXICO)
) ss.
COUNTY OF _____)

The foregoing instrument was acknowledged before me on _____, 20___, by _____

_____.
Notary Public
My Commission Expires: _____
(seal)