Personal Information

PERSONAL INFORMATION

NAME: .....

ADDRESSS: .....

CITY: ..... STATE: ..... ZIP: .....

CELLPHONE: ..... WORK PHONE NO.: .....

LICENSE NO.: .....

PASSPORT: .....

BIRTHDAY: ..... PLACE OF BIRTH:

.....

CITIZENSHIP: .....

FATHER'S NAME: .....

MOTHER'S NAME: .....

OFFSPRINGS: .....

IDENTIFICATION INFORMATION

NICKNAME: ..... BLOOD TYPE: .....

HEIGHT: ..... WEIGHT: .....

EYE COLOR: ..... HAIR COLOR: ..... SKIN TONE: .....

IDENTIFYING FEATURES

.....

.....

.....

.....

.....

Personal Information

MARITAL INFORMATION

MARITAL STATUS: ○ SINGLE ○ MARRIED ○ WIDOWED ○ DIVORCED ○ SEPARATED

DATE OF MARRIAGE:..... PLACE OF MARRIAGE: .....

CITY: ..... STATE: ..... ZIP: .....

SPOUSE / PARTNER INFORMATION

SPOUSE / PARTNER NAME: .....

DATE OF BIRTH: ..... PHONE: .....

ADDRESS: .....

CITY: ..... STATE: ..... ZIP: .....

AGREEMENTS (IF APPLICABLE): .....

NOTES: .....

.....

TAX INFORMATION

TAX ID NUMBER: .....

SOCIAL SECURITY NUMBER: .....

ACCOUNTANT: .....

PENSION NUMBER: ..... TAX AGENT: .....

EMPLOYMENT INFORMATION

EMPLOYER: .....

POSITION: ..... START DATE: .....

PHONE: ..... EMAIL: .....

ADDRESS: .....

CITY: ..... STATE: ..... ZIP: .....

Child Information

CHILD INFORMATION

CHILD RECENT PHOTO

FIRST NAME: ....

LAST NAME: ....

DATE OF BIRTH: ....

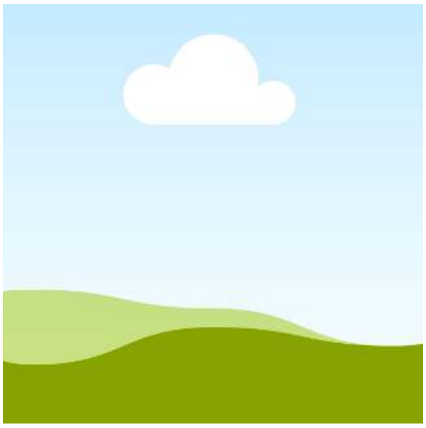
PHONE: ....

ADDRESS: ....

CITY: .... STATE: ....

ZIP: ....

NOTES: ....



CHILD RECENT PHOTO

FIRST NAME: ....

LAST NAME: ....

DATE OF BIRTH: ....

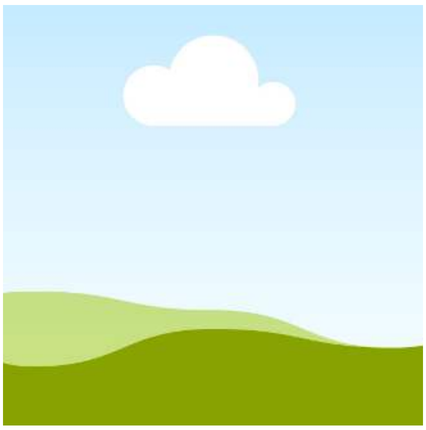
PHONE: ....

ADDRESS: ....

CITY: .... STATE: ....

ZIP: ....

NOTES: ....



CHILD RECENT PHOTO

FIRST NAME: ....

LAST NAME: ....

DATE OF BIRTH: ....

PHONE: ....

ADDRESS: ....

CITY: .... STATE: ....

ZIP: ....

NOTES: ....

Home Information

DATE MOVED INTO PROPERTY:

.....

ADDRESS	PEOPLE WHO LIVE HERE

MORTGAGE DETAILS

MORTGAGE WITH: .....

TYPE OF MORTGAGE: .....

MORTGAGE START DATE: .....

MORTGAGE END DATE: .....

TERMS: .....

TYPE OF PROPERTY: .....

.....

BUILT DATE: .....

AGE OF PROPERTY: .....

HOME IMPROVEMENT PLANS

Home Insurance Information

INSURANCE COVERS

.....

.....

.....

.....

.....

RATES / COST

.....

.....

.....

INSURANCE COMPANY INFORMATION

HOME INSURANCE COMPANY: .....

CONTACT NUMBER: .....

POLICY NUMBER: .....

DATE OF CLAIM	DESCRIPTION OF CLAIM	DATE PAID	COMPLETED

NOTES: .....

.....

Car Insurance Information

DETAILS	
MAKE:	MODEL:
YEAR:	VIN:
AGENT NAME:	PHONE:
EMAIL:	START DATE:
COMPANY:	POLICY#:
MAKE TO CLAIM:	
NOTES:	

DETAILS	
MAKE:	MODEL:
YEAR:	VIN:
AGENT NAME:	PHONE:
EMAIL:	START DATE:
COMPANY:	POLICY#:
MAKE TO CLAIM:	
NOTES:	

Health Insurance Information

DETAILS

INSURED PERSON:		
COMPANY:	ADDRESS:	
CITY:	STATE:	ZIP
AGENT NAME:	PHONE:	
EMAIL:	START DATE:	
POLICY#:		
HEALTH COVERAGE:		
DENTAL COVERAGE:		
VISION COVERAGE		
RX:	DEDUCTIBLE:	
NOTES:		

Life Insurance Information

DETAILS

INSURED PERSON:		
BENEFICIARY:		
BENEFIT:		
COMPANY:	POLICY#:	
ADDRESS:		
CITY:	STATE:	ZIP:
AGENT NAME:	PHONE:	
EMAIL:	START DATE:	
NOTES:		

Other Insurance Information

DETAILS

INSURANCE TYPE:	
COMPANY:	POLICY#:
AGENT NAME:	PHONE:
EMAIL:	START DATE:
RX:	DEDUCTIBLE:
MAKE TO CLAIM:	
NOTES:	

DETAILS

INSURANCE TYPE:	
COMPANY:	POLICY#:
AGENT NAME:	PHONE:
EMAIL:	START DATE:
RX:	DEDUCTIBLE:
MAKE TO CLAIM:	
NOTES:	

Pet Information

GENERAL INFORMATION

NAME:.....

BREED:..... COLOR: .....

GENDER: ..... WEIGHT: .....

DATE OF BIRTH: ..... AGE ADOPTED: .....

MICROCHIP NO.: .....

COLLAR TAG NO.: .....

SPECIAL MARKINGS: .....

CARE INFORMATION

FOOD: .....

FEEDING INFO: .....

HYGIENE INFO: .....

GROOMER: ..... PHONE: .....

ALLERGIES: .....

PEDIGREE INFORMATION / CERTIFICATES: .....

.....

.....

BREEDER / SELLER INFORMATION

NAME: .....

ADDRESS: .....

.....

CITY: ..... STATE: ..... ZIP: .....

EMAIL: .....

PHONE: .....

My Belongings

BELOW IS A LIST OF MY BELONGINGS AND WHO I WISH FOR THESE TO PASS ONTO

ITEM		TO BE GIVEN AWAY TO

Locate My Belongings

BELOW IS INFORMATION ON HOW TO FIND MY BELONGINGS

ITEM	LOCATION

Medical Contact List

NAME:

SPECIALITY:

PHONE 1: PHONE 2:

EMAIL:

ADDRESS:

NOTES:

NAME:

SPECIALITY:

PHONE 1: PHONE 2:

EMAIL:

ADDRESS:

NOTES:

NAME:

SPECIALITY:

PHONE 1: PHONE 2:

EMAIL:

ADDRESS:

NOTES:

Emergency Contacts List

FAMILY MEMBER
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

FAMILY MEMBER
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

FAMILY MEMBER
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

FRIEND
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

FRIEND
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

HEALTH CARE PROVIDER
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

HEALTH CARE PROVIDER
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

LEGAL REPRESENTATIVE
NAME:.....
ADDRESS:.....
.....
PHONE:.....
EMAIL:.....

Insurance Information

INSURANCE COMPANY:	
PLAN TYPE:	POLICYHOLDER:
GROUP:	ID#:
PHONE NUMBER:	WEBSITE:
USERNAME:	PASSWORD:
INSURANCE COMPANY:	

PLAN TYPE:	POLICYHOLDER:
GROUP:	ID#:
PHONE NUMBER:	WEBSITE:
USERNAME:	PASSWORD:
INSURANCE COMPANY:	
PLAN TYPE:	POLICYHOLDER:
GROUP:	ID#:
PHONE NUMBER:	WEBSITE:
USERNAME:	PASSWORD:
INSURANCE COMPANY:	
PLAN TYPE:	POLICYHOLDER:
GROUP:	ID#:
PHONE NUMBER:	WEBSITE:
USERNAME:	PASSWORD:

Hospital Information

HOSPITAL NAME	
ADDRESS	
SPECIALITY	
PHONE NUMBER	
PATIENT PORTAL WEBSITE	
USERNAME	

HOSPITAL NAME	
ADDRESS	
SPECIALITY	
PHONE NUMBER	
PATIENT PORTAL WEBSITE	
USERNAME	

HOSPITAL NAME	
ADDRESS	
SPECIALITY	
PHONE NUMBER	
PATIENT PORTAL WEBSITE	
USERNAME	

Pharmacy Information

NAME:

PHONE:

WEBISTE:

USERNAME: PASSWORD:

LOCATION:

NAME:

PHONE:

WEBISTE:

USERNAME: PASSWORD:

LOCATION:

NAME:

PHONE:

WEBISTE:

USERNAME: PASSWORD:

LOCATION:

NAME:

PHONE:

WEBISTE:

USERNAME: PASSWORD:

LOCATION:

Health Providers

PROVIDER:

NAME:

PROVIDER FOR:

TYPE OF CARE:

PHONE: EMAIL:

ADDRESS:

NOTES:

PROVIDER:

NAME:

PROVIDER FOR:

TYPE OF CARE:

PHONE: EMAIL:

ADDRESS:

NOTES:

PROVIDER:

NAME:

PROVIDER FOR:

TYPE OF CARE:

PHONE: EMAIL:

ADDRESS:

NOTES:

Personal Medical History

DATE OF BIRTH	BLOOD TYPE
PRIMATY DOCTOR	CONTACT

CHRONIC ILLNESSES / DISEASES / CONDITIONS

ALLERGIES

ALLERGY	NOTES	MEDICATION REQUIRED

SERIOUS ILLNESS / INJURY HISTORY

DATE	DESCRIPTION	NOTES	MEDICATION REQUIRED

Personal Health History

PRIMARY HEALTH CARE PROVIDER

NAME OF DOCTOR: .....

PHONE: .....

ADDRESS: .....

PERSONAL HEALTH HISTORY

	Acid Reflux
	Alcohol Addiction
	Allergy Problems
	Anemia
	Anxiety
	Artery / Vein Problems
	Arthritis
	Asthma
	Autoimmune Disease
	Bipolar Disorder
	Bladder Irritability
	Bleeding Problems
	Blood Clots
	Cancer
	Cataracts
	Colitis / Crohns
	Chronic Pain
	Depression
	Diabetes
	Drug Addiction
	Esophagitis, ulcers

	Fractures
	Gallstones
	Glaucoma
	Gout
	Headaches
	Hearing Impairment
	Heart Attack
	Heart Disease
	Heart Valve Problems
	Hepatitis A
	Hepatitis B
	Hepatitis C
	Hernia
	High Blood Pressure
	High Cholesterol
	HIV
	Irritable Bowel
	Kidney Disease
	Kidney Stones
	Liver Disease
	Lung Disease

	Mental Illness
	Migraines
	MRSA
	Osteoporosis
	Skin Infections
	Recurrent UTI
	PTSD
	Seizures
	STD’s
	Sleep Apnea
	Stoke
	TB
	Thyroid Disease
	Vision Impairment

Family Medical History

F = FATHER M = MOTHER GP = GRANDPARENTS S= SIBLINGS

	F	M	GP	S
Acid Reflux				
Alcohol Addiction				
Allergy Problems				
Anemia				
Anxiety				
Artery / Vein Problems				
Arthritis				
Asthma				
Autoimmune Disease				
Bipolar Disorder				
Bladder Irritability				
Bleeding Problems				
Blood Clots				
Cancer				
Cataracts				
Colitis / Crohns				
Chronic Pain				
Depression				
Diabetes				
Drug Addiction				
Esophagitis, ulcers				
Fractures				
Gallstones				
Glaucoma				
Gout				
Headaches				
Hearing Impairment				
Heart Attack				
Heart Disease				
Heart Valve Problems				

	F	M	GP	S
Hepatitis A				
Hepatitis B				
Hepatitis C				
Hernia				
High Blood Pressure				
High Cholesterol				
HIV				
Irritable Bowel				
Kidney Disease				
Kidney Stones				
Liver Disease				
Lung Disease				
Mental Illness				
Migraines				
MRSA				
Osteoporosis				
Skin Infections				
Recurrent UTI				
PTSD				
Seizures				
STD's				
Sleep Apnea				
Stoke				
TB				
Thyroid Disease				
Vision Impairment				

Medical Appointment Planner

DOCTOR:

DATE & TIME:

CONTACT:

LOCATION:

REASON FOR VISIT

PRESCRIPTION

QUESTIONS / NOTES

NEXT APPOINTMENT:

DOCTOR:

DATE & TIME:

CONTACT:

LOCATION:

REASON FOR VISIT

PRESCRIPTION

QUESTIONS / NOTES

NEXT APPOINTMENT:

Doctor Visits

..... YEAR

DATE	DOCTOR	VISIT DESCRIPTION	MEDICATION

Doctor Notes

DATE:

TIME:

REASON FOR CONSULTATION	
DURATION	
COMMUNICATION METHOD	

POINT DISCUSSES

TO DO

Medication Tracker

MEDICATION NAME	DATE	TIME	M	T	W	T	F	S	S

INSTRUCTIONS / PRECAUTIONS / ADVERSE REACTIONS

Medication Log

DATE	TIME	MEDICATION	DONE	NOTES

Medication Spending Record

DATE	AMOUNT	DESCRIPTION

Medical Expenses

DATE	DESCRIPTION	EXPENSES			
		TOTAL	INSURANCE	OUT OF POCKET	BALANCE

Vaccine Record

YEAR:

DATE	VACCINE	DOCTOR	REACTION/NOTES

Surgical History

PROCEDURE	DATE
FACILITY	PHYSICIAN
REASON FOR PROCEDURE	

NOTES AFTER SURGERY

Lab Results Tracker

DATE	TEST TYPE	RESULTS	FOLLOW-UP

Lab Results Tracker

TEST TYPE:	
DATE:	PROVIDER:
RESULTS:	

TEST TYPE:	
DATE:	PROVIDER:
RESULTS:	

TEST TYPE:	
DATE:	PROVIDER:
RESULTS:	

TEST TYPE:	
DATE:	PROVIDER:
RESULTS:	

Medical Notes

Radiology Log

DATE	RADIOLOGY REQUEST	REASONS	ORDERED BY	FINDING/S

Medication Intake Tracker

MONTH:......................................

WEEK:...............................

DETAILS	DOSE	TIME	M	T	W	T	F	S	S

WEEK:...............................

DETAILS	DOSE	TIME	M	T	W	T	F	S	S

WEEK:...............................

DETAILS	DOSE	TIME	M	T	W	T	F	S	S

WEEK:.....

DETAILS	DOSE	TIME	M	T	W	T	F	S	S

WEEK:.....

DETAILS	DOSE	TIME	M	T	W	T	F	S	S

NOTES

Food Allergy Tracker

FOOD	DATE EATEN	REACTION TIMING
		IMMEDIATE
		WITHIN 24 HOURS
		2-3 DAYS

SYMTOMS			
ABDOMINAL PAIN	BREATHING DIFFICULTY	CONSTIPATION	COUGHING
DIARRHEA	EYE IRRATATION	GAS	HYPERACTIVITY
IRRITABLE	LETHARGIC	RUNNY NOSE	SKIN RASH
SLEEP LOSS	SLEEPINESS	SNEEZING	SORE JOINTS
STUFFY NOSE	SWELLING	VOMITING	

NOTES:

FOOD	DATE EATEN	REACTION TIMING
		IMMEDIATE
		WITHIN 24 HOURS
		2-3 DAYS

SYMTOMS			
ABDOMINAL PAIN	BREATHING DIFFICULTY	CONSTIPATION	COUGHING
DIARRHEA	EYE IRRATATION	GAS	HYPERACTIVITY
IRRITABLE	LETHARGIC	RUNNY NOSE	SKIN RASH
SLEEP LOSS	SLEEPINESS	SNEEZING	SORE JOINTS
STUFFY NOSE	SWELLING	VOMITING	

NOTES:

Account Tracker

ACCOUNT - 1	
NAME OF ACCOUNT:	
ACCOUNT NUMBER:	
FINANCIAL INSTITUTION:	
ACCOUNT TYPE:	ROUTING / TRANSIT#:
CARD NUMBER:	
NOTES:	

ACCOUNT - 1	
NAME OF ACCOUNT:	
ACCOUNT NUMBER:	
FINANCIAL INSTITUTION:	
ACCOUNT TYPE:	ROUTING / TRANSIT#:
CARD NUMBER:	
NOTES:	

ACCOUNT - 1	
NAME OF ACCOUNT:	
ACCOUNT NUMBER:	
FINANCIAL INSTITUTION:	
ACCOUNT TYPE:	ROUTING / TRANSIT#:
CARD NUMBER:	
NOTES:	

Credit Card Info

CREDIT CARD

CREDIT CARD NO.:	DUE DATE:
CARD NUMBER:	
ACCOUNT NO.:	MINIMUM PAYMENT:
BENEFITS / REWARDS:	
PAY VIA: ◯ MAIL ◯ AUTO PAY ◯ ONLINE - WEBSITE	
USERNAME:	PASSWORD:
PAY ADDRESS:	
CITY:	ZIP:
MONTHLY PAYMENT:	

CREDIT CARD

CREDIT CARD NO.:	DUE DATE:
CARD NUMBER:	
ACCOUNT NO.:	MINIMUM PAYMENT:
BENEFITS / REWARDS:	
PAY VIA: ◯ MAIL ◯ AUTO PAY ◯ ONLINE - WEBSITE	
USERNAME:	PASSWORD:
PAY ADDRESS:	
CITY:	ZIP:
MONTHLY PAYMENT:	

Investment Info

INVESTMENT ACCOUNT NO.1

ACCOUNT TYPE:	
CUSTODIAN:	ACCOUNT NO.:
ADVISOR:	
PHONE:	
WEBSITE:	
USERNAME:	PASSWORD:

INVESTMENT ACCOUNT NO.1

ACCOUNT TYPE:	
CUSTODIAN:	ACCOUNT NO.:
ADVISOR:	
PHONE:	
WEBSITE:	
USERNAME:	PASSWORD:

INVESTMENT ACCOUNT NO.1

ACCOUNT TYPE:	
CUSTODIAN:	ACCOUNT NO.:
ADVISOR:	
PHONE:	
WEBSITE:	
USERNAME:	PASSWORD:

Jewelry And Colletibles

DESCRIPTION	YEAR	SERIAL NO.	VALUE	RECIPIENT

Retirement Account Info

ACCOUNT DETAILS	
COMPANY:	
TYPE OF RETIREMENT:	
ACCOUNT / WEBSITE:	
ACCOUNT NUMBER:	
USERNAME:	PASSWORD:
CURRENT VALUE:	
NOTES:	

ACCOUNT DETAILS	
COMPANY:	
TYPE OF RETIREMENT:	
ACCOUNT / WEBSITE:	
ACCOUNT NUMBER:	
USERNAME:	PASSWORD:
CURRENT VALUE:	
NOTES:	

Retirement Tracker

COMPANY:	TYPE OF RETIREMENT:

RETIREMENT FUNDS

DATE	CONTRIBUTIONS	BALANCE	NOTES

Income Tracker

MONTH OF :

DATE	DESCRIPTION	SOURCE	AMOUNT

Expense Tracker

MONTH OF :

DATE	CATEGORY	DESCRIPTION	AMOUNT	BALANCE

Bill Planner

BILL	DUE DATE	AMOUNT	PAID
	TOTAL		

Utility Expenses

TYPE:	DAY OF PAYMENT DUE:
COMPANY:	ACCOUNT NO.:
PAYMENT ADDRESS:	
PHONE:	WEBSITE:
USERNAME:	PASSWORD:
CURRENT AMOUNT:	AUTO PAYMENT? ◯ YES ◯ NO

TYPE:	DAY OF PAYMENT DUE:
COMPANY:	ACCOUNT NO.:
PAYMENT ADDRESS:	
PHONE:	WEBSITE:
USERNAME:	PASSWORD:
CURRENT AMOUNT:	AUTO PAYMENT? ◯ YES ◯ NO

TYPE:	DAY OF PAYMENT DUE:
COMPANY:	ACCOUNT NO.:
PAYMENT ADDRESS:	
PHONE:	WEBSITE:
USERNAME:	PASSWORD:
CURRENT AMOUNT:	AUTO PAYMENT? ◯ YES ◯ NO

TYPE:	DAY OF PAYMENT DUE:
COMPANY:	ACCOUNT NO.:
PAYMENT ADDRESS:	
PHONE:	WEBSITE:
USERNAME:	PASSWORD:
CURRENT AMOUNT:	AUTO PAYMENT? ◯ YES ◯ NO

Debt Info

CREDITOR:	
TYPE OF LOAN:	
INTEREST RATE:	MINIMUM PAYMENT:
DEBT AMOUNT:	
DATE TODAY:	
PAY OFF DEBT BY:	
MONTH 1:	MONTH 7:
MONTH 2:	MONTH 8:
MONTH 3:	MONTH 9:
MONTH 4:	MONTH 10:
MONTH 5:	MONTH 11:
MONTH 6:	MONTH 12:

CREDITOR:	
TYPE OF LOAN:	
INTEREST RATE:	MINIMUM PAYMENT:
DEBT AMOUNT:	
DATE TODAY:	
PAY OFF DEBT BY:	
MONTH 1:	MONTH 7:
MONTH 2:	MONTH 8:
MONTH 3:	MONTH 9:
MONTH 4:	MONTH 10:
MONTH 5:	MONTH 11:
MONTH 6:	MONTH 12:

CREDITOR:	
TYPE OF LOAN:	
INTEREST RATE:	MINIMUM PAYMENT:
DEBT AMOUNT:	
DATE TODAY:	
PAY OFF DEBT BY:	
MONTH 1:	MONTH 7:
MONTH 2:	MONTH 8:
MONTH 3:	MONTH 9:
MONTH 4:	MONTH 10:
MONTH 5:	MONTH 11:
MONTH 6:	MONTH 12:

CREDITOR:	
TYPE OF LOAN:	
INTEREST RATE:	MINIMUM PAYMENT:
DEBT AMOUNT:	
DATE TODAY:	
PAY OFF DEBT BY:	
MONTH 1:	MONTH 7:
MONTH 2:	MONTH 8:
MONTH 3:	MONTH 9:
MONTH 4:	MONTH 10:
MONTH 5:	MONTH 11:
MONTH 6:	MONTH 12:

Valueables in Storage

SAFETY DEPOSIT BOX

BANK NAME:		BOX#
ADDRESS:		
CITY:	STATE:	ZIP:
ACCESS DETAILS:		
DESCRIPTION:		

BANK NAME:		BOX#
ADDRESS:		
CITY:	STATE:	ZIP:
ACCESS DETAILS:		
DESCRIPTION:		

Asset List

ASSET TYPE	DESCRIPTION	VALUE	INSURED?
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N

Assets and Liabilities

ASSETS

CATEGORY	ASSET DESCRIPTION	VALUE

LIABILITIES

CATEGORY	LIABILITY DESCRIPTION	VALUE

Net Worth Tracker

ASSETS

ASSET	VALUE
TOTAL ASSETS	

LIABILITIES

LIABILITIES	VALUE
TOTAL LIABILITIES	

TOTAL ASSETS	TOTAL LIABILITIES
NET WORTH:	

NET WORTH = TOTAL ASSETS - TOTAL LIABILITIES

NOTES:

Snowball Tracker

MONTH :

	DEBT	TOTAL AMOUNT DUE	MINIMUM PAYMENT	DEBT SNOWBALL PAYMENT
JAN				
FEB				
MAR				
APR				
MAY				
JUN				
JUL				
AUG				
SEP				
OCT				
NOV				
DEC				

Debt Snowball Tracker

MONTH OF

CREDITOR

ACCOUNT #

AMOUNT

DUE DATE

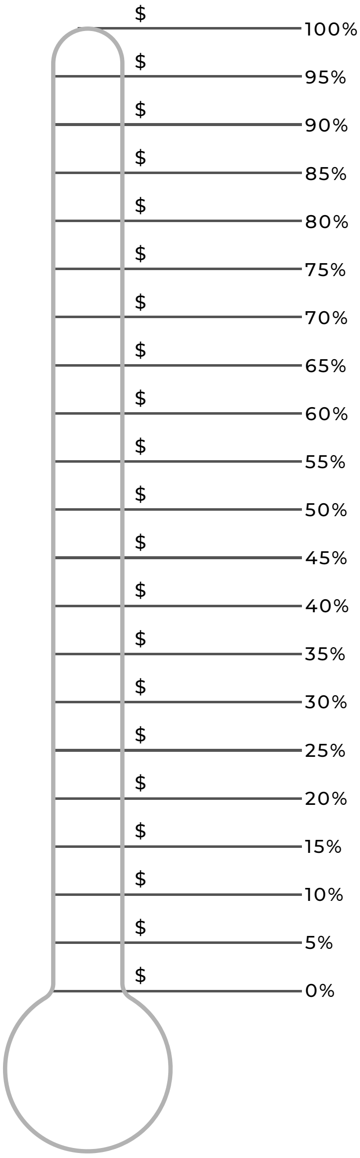
INTEREST RATE

GOAL PAYOFF DATE

MINIMUM PAYMENT

DATE	ACCOUNT	BALANCE	NOTES

VISUAL PAYOFF PROGRESS



Payment Tracker

STARTING BALANCE :	INTEREST RATE :
CREDITOR :	GOAL PAYOFF DATE :

DATE	PAYMENT	BALANCE	NOTES

Important Documents

DOCUMENTS
ID CARDS
BIRTH CERTIFICATES
MARRIAGE CERTIFICATES
DEATH CERTIFICATES
COPIES OF WILLS, POWER OF ATTORNEY, PERSONAL WISHES
IMMUNISATION RECORDS
DEEDS / TITLES / MORTGAGES INFORMATION
IMMIGRATION PAPERS
CITIZENSHIP PAPERS
COPIES OF PASSPORTS, LICENSES, ID CARDS
MEDICARE CARDS
CREDIT CARDS
DRIVERS' LICENSES
INSURANCE CARDS
VEHICLE REGISTRATIONS, TITLES
ANY CONTRACTS

Access to Documents

DOCUMENT TYPE	DOCUMENT LOCATION
Birth Certificate	
Social Security Cards	
Passports	
Copies of Drivers' Licenses	
Marriage Certificates	
Adoption Papers	
Last Will & Testament	
Living Will	
Trust	
Power of Attorney	
Organ Donor Directives	
Medical Records	
Property Deeds	
Mortgage records	
Health Insurance Policy	
Life Insurance Policy	
Car Insurance Policy	
Home Insurance Policy	
Property for Assessments	
Retirement Account Info	

Master Document List

DOCUMENTS	CATEGORY	NOTES	✓
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
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			☐
			☐
			☐
			☐
			☐

Living Will

This document contains two parts. Both parts are for use when you can no longer communicate your health care wishes to your doctors. You may choose to sign one or the other or both.

The first form is called a Health Care Directive, also known as a living will. The Health Care Directive allows you to tell your health care providers your preferences for end of life treatment.

The second form is called a Health Care Power of Attorney. This Health Care Power of Attorney allows you to appoint another person to make health care decisions on your behalf taking into account your wishes.

This form was completed and signed on _____, 20____.

I. HEALTH CARE DIRECTIVE (LIVING WILL)
(If you do not wish to fill out this form and just wish to designate a health care agent, draw an "X" through the following section)

I, _____, with a mailing address of _____, with the last four (4) digits of my social security number (SSN) being xxx-xx-_____ (Hereinafter may be referred to as the 'Principal') desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

A. LIFE SUPPORT
I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

_____ □ - Chronic coma or persistent vegetative state
_____ □ - No longer able to communicate my needs
_____ □ - No longer able to recognize family or friends
_____ □ - Total dependence on others for daily care
_____ □ - Other: _____.

(initial and check one)

_____ □ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

_____ □ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

B. CERTAIN LIFE-SUSTAINING TREATMENT: (You do not have to initial and check any of these if you do not wish to)

Some people do not wish to have certain life sustaining treatments under any circumstance, even if recovery is a possibility. Check treatments below, if any, that you do not wish to have under any circumstances (initial and check all that apply):

_____ □ - Cardiopulmonary Resuscitation (CPR)
_____ □ - Ventilation (breathing machine)
_____ □ - Feeding tube
_____ □ - Dialysis
_____ □ - Other: _____.

C. END OF LIFE WISHES (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that:
_____
_____
_____
_____

II. HEALTH CARE (MEDICAL) POWER OF ATTORNEY WITH MENTAL HEALTH AUTHORITY

It provides peace of mind to be able to choose someone you know and who knows you to make healthcare decisions on your behalf when you no longer can communicate your wishes. It is important that you discuss your wishes with your health care agent so they can be sure to make sure your wishes are carried out by the health care providers. If you DO NOT, however, choose someone to make decisions for you, write NONE in the line for the agent's name.

I, _____, as Principal, designate _____, as my agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations and related health care. This power of attorney is effective at the point when I am not longer able to communicate my health care wishes. My agent's decisions under this power of attorney, during any period when I am unable to make and/or communicate my health care decisions or when there is

uncertainty as to whether I am dead or alive, are binding on my heirs, devisees and personal representatives.

My agent's address and phone number are as follows:

Phone: _____
Address: _____

(initial and check all that apply)

_____ □ - I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician. (Initial if this is your choice)
_____ □ - This Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated. (Initial if this is your choice)

If my agent is unwilling or unable to serve, I hereby appoint as my successor agent:

Successor Agent's Name: _____
Phone: _____
Address: _____

I intend for my agent to receive any and all of my health records and information as if I were the one requesting such information. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of _____
_____

I have signed this document on this _____, 20____.

Principal's Signature: _____
Print Name: _____

You may either choose two (2) witnesses and/or a notary to acknowledge your signature.

Witness Acknowledgment

On the date set forth above, I hereby state as follows:

The above named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and I am not an agent or successor agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness 1

Witness 1 Signature: _____
Print Name: _____
Phone: _____
Address: _____

Witness 2

Witness 2 Signature: _____
Print Name: _____
Phone: _____
Address: _____

Notary Acknowledgment

State of _____ }
County of _____ }

Signed and sworn to me on the ___ day of _____, in the year 20___.

I, the undersigned authority in and for said County in said State, hereby certify that the

Principal _____, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the day the same bears date.

Given under my hand this _____, 20____.

Notary Public Signature _____
Printed Name: _____.
My commission expires: _____

(Notary Seal)

Last Will and Testament

Last Will and Testament
of.....

I, _____, resident in the City of _____, County of _____, State of _____, being of sound mind, not acting under duress or undue influence, and fully understanding the nature and extent of all my property and of this disposition thereof, do hereby make, publish, and declare this document to be my Last Will and Testament, and hereby revoke any and all other wills and codicils heretofore made by me.

I. EXPENSES & TAXES

I direct that all my debts, and expenses of my last illness, funeral, and burial, be paid as soon after my death as may be reasonably convenient, and I hereby authorize my Personal Representative, hereinafter appointed, to settle and discharge, in his or her absolute discretion, any claims made against my estate.

I further direct that my Personal Representative shall pay out of my estate any and all estate and inheritance taxes payable by reason of my death in respect of all items included in the computation of such taxes, whether passing under this Will or otherwise. Said taxes shall be paid by my Personal Representative as if such taxes were my debts without recovery of any part of such tax payments from anyone who receives any item included in such computation.

II. PERSONAL REPRESENTATIVE

I nominate and appoint _____, of _____, County of _____, State of _____ as Personal Representative of my estate and I request that (he/she) be appointed temporary Personal Representative if (he/she) applies. If my Personal Representative fails or ceases to so serve, then I nominate_____ of _____, County of _____, State of _____ to serve.

III. DISPOSITION OF PROPERTY

I devise and bequeath my property, both real and personal and wherever situated, as follows:

1st Beneficiary

_____ [full name], currently of _____ [address], as my _____ [relation] whose last four (4) digits of their
Social Security Number (SSN) are xxx-xx-_____ with the following property:

_____

2nd Beneficiary
_____ [full name], currently of _____
[address], as my _____ [relation] whose last four (4) digits of their
Social Security Number (SSN) are xxx-xx-_____ with the following property:
_____

3rd Beneficiary
_____ [full name], currently of _____
[address], as my _____ [relation] whose last four (4) digits of their
Social Security Number (SSN) are xxx-xx-_____ with the following property:
_____

If any of my beneficiaries have pre-deceased me, then any property that they would have received if they had not pre-deceased me shall be distributed in equal shares to the remaining beneficiaries. If any of my property cannot be readily sold and distributed, then it may be donated to any charitable organization or organizations of my Personal Representative's choice. If any property cannot be readily sold or donated, my Personal Representative may, without liability, dispose of such property as my Personal Representative may deem appropriate. I authorize my Personal Representative to pay as an administration expense of my estate the expense of selling, advertising for sale, packing, shipping, insuring and delivering such property.

IV. OMISSION
Except to the extent that I have included them in this Will, I have intentionally, and not as a result of any mistake or inadvertence, omitted in this Will to provide for any family members and/or issue of mine, if any, however defined by law, presently living or hereafter born or adopted.

V. BOND
No bond shall be required of any fiduciary serving hereunder, whether or not specifically named in this Will, or if a bond is required by law, then no surety will be required on such bond.

VI. DISCRETIONARY POWERS OF PERSONAL REPRESENTATIVE
My Personal Representative, shall have and may exercise the following discretionary powers in addition to any common law or statutory powers without the necessity of court license or approval:

A. To retain for whatever period my Personal Representative deems advisable any property, including property owned by me at my death, and to invest and reinvest in any property, both real and personal, regardless of whether any particular investment would be proper for a Personal Representative and regardless of the extent of diversification of the assets held hereunder.

B. To sell and to grant options to purchase all or any part of my estate, both real and personal, at any time, at public or private sale, for consideration, whether or not the highest possible consideration, and upon terms, including credit, as my Personal Representative deems advisable, and to execute, acknowledge, and deliver deeds or other instruments in connection therewith.
C. To lease any real estate for terms and conditions as my Personal Representative deems advisable, including the granting of options to renew, options to extend the term or terms, and options to purchase.
D. To pay, compromise, settle or otherwise adjust any claims, including taxes, asserted in favor of or against me, my estate or my Personal Representative.
E. To make any separation into shares in whole or in part in kind and at values determined by my Personal Representative, with or without regard to tax basis, and to allocate different kinds and disproportionate amounts of property and undivided interests in property among the shares.
F. To make such elections under the tax laws as my Personal Representative shall deem appropriate, including elections with respect to qualified terminable interest property, exemptions and the use of deductions as income tax or estate tax deductions, and to determine whether to make any adjustments between income and principal on account of any election so made.
G. To make any elections permitted under any pension, profit sharing, employee stock ownership or other benefit plan.
H. To employ others in connection with the administration of my estate, including legal counsel, investment advisors, brokers, accountants and agents and to pay reasonable compensation in addition to my Personal Representative's compensation.
I. To vote any shares of stock or other securities in person or by proxy; to assert or waive any stockholder's rights or privilege to subscribe for or otherwise acquire additional stock; to deposit securities in any voting trust or with any committee.
J. To borrow and to pledge or mortgage any property as collateral, and to make secured or unsecured loans. My Personal Representative is specifically authorized to make loans without interest to any beneficiary hereunder. No individual or entity loaning property to my Personal Representative or trustee shall be held to see to the application of such property.
K. My Personal Representative shall also in his or her absolute discretion determine the allocation of any GST exemption available to me at my death to property passing under this Will or otherwise. The determination of my Personal Representative with respect to any elections or allocation, if made or taken in good faith, shall be binding upon all affected.

VII. CONTESTING BENEFICIARY

If any beneficiary under this Will, or any trust herein mentioned, contests or attacks this Will or any of its provisions, any share or interest in my estate given to that contesting beneficiary under this Will is revoked and shall be disposed of in the same manner provided herein as if that contesting beneficiary had predeceased me.

VIII. GUARDIAN AD LITEM NOT REQUIRED
I direct that the representation by a guardian ad litem of the interests of persons unborn, unascertained or legally incompetent to act in proceedings for the allowance of accounts hereunder be dispensed with to the extent permitted by law.

IX. GENDER
Whenever the context permits, the term "Personal Representative" shall include "Executor" and "Administrator," the use of a particular gender shall include any other gender, and references to the singular or the plural shall be interchangeable. All references to the Internal Revenue Code shall mean the Internal Revenue Code of 1986 or any successor Code. All references to estate taxes shall include inheritance and other death taxes.

X. ASSIGNMENT
The interest of any beneficiary in this Will, shall not be alienable, assignable, attachable, transferable nor paid by way of anticipation, nor in compliance with any order, assignment or covenant and shall not be applied to, or held liable for, any of their debts or obligations either in law or equity and shall not in any event pass to his, her, or their assignee under any instrument or under any insolvency or bankruptcy law, and shall not be subject to the interference or control of creditors, spouses or others.

XI. GOVERNING LAW
This document shall be governed by the laws of the State of _____.

XII. BINDING ARRANGEMENT
Any decision by my Personal Representative with respect to any discretionary power hereunder shall be final and binding on all persons interested. Unless due to my Executor's own willful default or gross negligence, no Executor shall be liable for said Executor's acts or omissions or those of any co-Executor or prior Executor.

I, the undersigned _____, do hereby declare that I sign and execute this instrument as my last Will, that I sign it willingly in the presence of each of the undersigned witnesses, and that I execute it as my free and voluntary act for the purposes herein expressed, on this _____ day of _____, 20_____.

_____ _____

Testator Signature Testator (Printed Name)

The foregoing instrument, was on this _____ day of _____, 20_____, subscribed on each page and at the end thereof by _____, the above-named Testator, and by (him/her) signed, sealed, published and declared to be (his/her) LAST WILL AND TESTAMENT, in the presence of us and each of us, who thereupon, at (his/her) request, in (his/her) presence, and in the presence of each other, have hereunto subscribed our names as attesting witnesses thereto.

_____ _____
Witness Signature Address

_____ _____
Witness Signature Address

TESTAMENTARY AFFIDAVIT
STATE OF _____
COUNTY OF _____, SS.

Before me, the undersigned authority, on this day personally appeared _____, testator, _____, witness and _____, witness, known to me to be the testator and the witnesses, respectively, whose names are signed to the attached or foregoing instrument, and, all of these persons being by me duly sworn, the testator declared to me and to the witnesses in my presence that the instrument is the testator's last will and that the testator has willingly signed or directed another to sign for him/her, and that the testator executed it as the testator's free and voluntary act for the purposes therein expressed; and each of the witnesses stated to me, in the presence of the testator, that they signed the will as witnesses and that to the best of their knowledge the testator was eighteen (18) years of age or over, of sound mind and under no constraint or undue influence.

_____ _____
Testator Signature Witness Signature

_____
Witness Signature

Subscribed and sworn to before me by the said testator and the said witnesses, this _____ day of _____, 20____.

_____
Notary Public
My Commission expires:

People to Contact

CONTACT

NAME: RELATION:

EMAIL: PHONE NO.:

ADDRESS:

CONTACT

NAME: RELATION:

EMAIL: PHONE NO.:

ADDRESS:

CONTACT

NAME: RELATION:

EMAIL: PHONE NO.:

ADDRESS:

CONTACT

NAME: RELATION:

EMAIL: PHONE NO.:

ADDRESS:

CONTACT

NAME: RELATION:

EMAIL: PHONE NO.:

ADDRESS:

Funeral Arrangements

PREFERRED FUNERAL HOME

FUNERAL HOME NAME:	
CONTACT:	PHONE NO.:
ADDRESS:	

PREFERRED FUNERAL PREFERENCES

I WANT TO BE : ◯ BURRIED ◯ CREMATED	VISITATION WITH FAMILY: ◯ YES ◯ NO
SERVICE AT CHURCH:	PHONE NO.:
GRAVESIDE SERVICE:	
PAID FOR:	PHONE:
CASKET PREFERENCES: ◯ OPEN CASKET ◯ CLOSED CASKET ◯ NOT AVAILABLE	
CLOTHING TO BE SELECTED OR COLLECTED BY:	
CLOTHING: ◯ NEW ◯ EXISTING ◯ N/A	
JEWELRY TO BE SELECTED OR COLLECTED BY:	
JEWELRY: ◯ NEW ◯ EXISTING ◯ RETURN AFTER SERVICE ◯ LEAVE ON FOR BURIAL ◯ N/A	
HAIR & MAKE UP: ◯ PERSONAL HAIRDRESSER ◯ MORTUARY COSMETOGLOGIST	
FUNERAL HOME NAME:	SPECIAL SERVICE VETERAN:
FLOWER ON CASKET:	
NEWSPAPER NOTICES:	
DVD WITH PICTURES:	MUSIC:
READING:	GRAVEMARKER:

FUNERAL EXPENSES

POLICY:	
COMPANY:	PHONE NO.:
I HAVE PREPAID FUNERAL EXPENSES: ◯ YES ◯ NO HOW MUCH?	
PAYMENT METHOD: ◯ PREPAID PACKAGE ◯ SAVING ACCOUNT ◯ LIFE INSURANCE	
◯ BURIAL FUNDS ◯ FUNERAL TRUST ◯ FUNERAL INSURANCE	
◯ BURIAL BENEFITS - APPROVED FOR PRE-NEED ELIGIBILITY? : ◯ OTHER:	

End of Life Worksheet

FULL LEGAL NAME:
DATE OF BIRTH:
PREFERRED HOSPITAL:
ATTENDING DOCTOR:

MEDICAL POWER OF ATTORNEY

☐ I WOULD LIKE TO DESIGNATE A MEDICAL POWER OF ATTORNEY (POA) TO MAKE HEALTHCARE DECISIONS ON MY BEHALF IF I BECOME UNABLE TO COMMUNICATE OR MAKE DECISIONS.

POWER OF ATTORNEY NAME:
RELATIONSHIP
CONTACT:
ADDRESS:

NOTES

END - OF - LIFE CARE PREFERENCES

PREFERRED LOCATION FOR END-OF-LIFE CARE
INDIVIDUAL I WOULD LIKE TO HAVE PRESENT DURING END-OF-LIFE CARE AND DEATH

NOTES

End of Life Worksheet

THIS IS NOT AN OFFICIAL FORM. IT IS NOT LEGALLY OR MEDICALLY BINDING.

POA

I ☐ DO ☐ DO NOT WISH TO APPOINT A MEDICAL POWER OF ATTORNEY (POA) TO MAKE HEALTH-RELATED DECISIONS ON MY BEHALF IN THE EVENT THAT I AM INCAPACITATED TO THE POINT THAT I AM UNABLE TO MAKE OR RELATE MY OWN DECISIONS.

POA NAME:	RELATION:
EMAIL:	PHONE:
ADDRESS:	

POA ☐ has been asked ☐ is willing
☐ is willing until / unless .....

LIFE SUPPORT

☐ I would like to have CPR (resuscitation) attempted if I do not have a pulse/breathing

☐ I do not want to have resuscitation attempted if I do not have a pulse/breathting (DNR)

☐ I would like medical staff to perform life-saving measure on me, including medication, surgery, or life-support, unless my quality of life has decreased to any of the following parameters:

- ☐ I am in a persistent vegetative state or coma
- ☐ I am fully dependent on others for mundane care
- ☐ I am in terrible, constant pain that will not improve
- ☐ I am no longer able to communicate by any means
- ☐ I no longer recognize anyone

If my quality of life has decreased to this point, I would like only comfort / palliative care

☐ I do NOT want the following life-support measures to be used (check all that apply);

- ☐ Feeding tube
- ☐ IV
- ☐ Breathing tube
- ☐ Antibiotics
- ☐ Painkillers
- ☐ Surgery

END OF LIFE CARE

I would prefer to receive end-of-life care ☐ at the hospital ☐ at home ☐ in hospice

I would like ☐ family ☐ friends ☐ religious officiant(s) ☐ medical staff

I would like religious end-of-life services on my deathbed from.....
.....

End Of Life Directives

LAST WILL AND TESTAMENT

FAMILY MEMBER:	PHONE NO.:
LOCATION OF DOCUMENT:	
EXECUTOR:	PHONE:
PREPARED BY:	PHONE:
ADDRESS:	

TRUST AGREEMENT

FAMILY MEMBER:	PHONE NO.:
LOCATION OF DOCUMENT:	
TRUSTEE	PHONE:
PREPARED BY:	PHONE:
ADDRESS:	

HEALTH CARE POWER OF ATTORNEY

FAMILY MEMBER:	PHONE NO.:
LOCATION OF DOCUMENT:	
PERSON:	PHONE:
PREPARED BY:	PHONE:
ADDRESS:	

FINANCIAL POWER OF ATTORNEY

FAMILY MEMBER:	PHONE NO.:
LOCATION OF DOCUMENT:	
PERSON:	PHONE:
PREPARED BY:	PHONE:
ADDRESS:	

Body Disposal Worksheet

DONATION

- [ ] I would like to be an organ and tissue donor
- [ ] I would like to be an organ and tissue donor except for my.....
- [ ] I would like to donate my whole body to medical research
    - [ ] I have already made arrangements with the following institute:

Research Facility:..... Contact:.....
Email:..... Phone:.....
Address:.....

DISPOSAL

- [ ] I would like to be cremated
- [ ] I would like aquamation (water cremation)
- [ ] I would like to be embalmed
- [ ] I do not want my body latered

FINAL RESTING

- [ ] I would like to be buried in the earth in: [ ] a casket [ ] an urn [ ] an eco - friendly container
- [ ] I have already purchased the container for my burial from:

Company:..... Contact:.....

- [ ] I have made arrangements for a plot at:

Cemetery:..... Contact:.....
Address: ..... Plot No.:.....

- [ ] I would like my body laid to rest in a [ ] crypt [ ] mausoleum
- [ ] I have made arrangements for a crypt / mausoleum at:

Location:..... contact:.....

- [ ] I would like my ashes scattered
    - [ ] I would prefer my loved ones choose the time and place of the scattering
    - [ ] I would like my ashes scattered according to the following parameters:

.....

- [ ] I would like my ashes displayed
    - [ ] I would prefer my loved ones choose the container and final display location of the ashes
    - [ ] I would like my ashes displayed according to the following parameter:

.....

- [ ] I would like to be buried at the sea

Final WishesWorksheet

- [ ] I would like my family and friends to know that I love them
- [ ] I would like my family and friends to know that I am now at peace
- [ ] I would like my family and friends to think of me before my illness/injury/dying
- [ ] I would like my family and friends to focus on the good times we had together
- [ ] I would like my family and friends to move on and grow and change in their lives without feeling guilty at my absence
- [ ] I would like my family and friends to make peace with my memory if they are able
- [ ] I would like my family and friends to seek counseling for any lingering grief
- [ ] I would like my family and friends to remember me fondly, not with sadness
- [ ] I would like my family and friends to celebrate my life, not mourn my death
- [ ] I would like my family and friends to use the inheritance and gifts I have given them to improve themselves, care for their families, and give back to their communities
- [ ] .....
- [ ] .....
- [ ] .....
- [ ] .....
- [ ] .....
- [ ] .....

I would like to be remembered in the following way:

.....

.....

.....

.....

.....

.....

I would like to be memorialized in the following way:

.....

.....

.....

.....

.....

.....

Final Wishes

LAST WISHES	NOTES	✓

Final Wishes

IN THE FOLLOWING WAYS, I WOULD LIKE TO BE REMEMBERED

RECALLING MY PRESENCE

IN THE FOLLOWING WAYS, I WOULD LIKE TO BE MEMORIALIZED

COMMEMORATE ME

Headstone Planning

NAME	DATE

EPITAPH

HEADSTONE

MATERIAL:
SIZE:
SHAPE:
FONT STYLE:
COLOR:
SYMBOL&MEANING:
MAXIMUM HEADSTONE COST:

Obituary Information

PERSONAL INFORMATION

FULL LEGAL NAME:
MAIDEN NAME:
DATE OF BIRTH:
PLACE OF BIRTH:

SURVIVED BY

SPOUSE:
CHILDREN:
GRANDCHILDREN:
PETS:

ACHIEVEMENTS

AFFILIATIONS

NOTES

Obituary Content

Message for My Beneficiaries

Items to Donate

ITEMS	DONATE TO	✓

Items to Destroy

ITEMS	✓

Letter of Intent

Letter of Gratitude

Note to Family Members

Electronic Device Login

DEVICE:

USERNAME:	NOTES:
PASSWORD:	

DEVICE:

USERNAME:	NOTES:
PASSWORD:	

DEVICE:

USERNAME:	NOTES:
PASSWORD:	

DEVICE:

USERNAME:	NOTES:
PASSWORD:	

Website Log-in

WEBSITE	USERNAME	PASSWORD

Social Media Accounts

PLATFORM:

USERNAME:	NOTES:
PASSWORD:	

PLATFORM:

USERNAME:	NOTES:
PASSWORD:	

PLATFORM:

USERNAME:	NOTES:
PASSWORD:	

PLATFORM:

USERNAME:	NOTES:
PASSWORD:	

Security Questions & Passwords

WEBSITE	QUESTIONS	ANSWERS

Home Security Passwords

DEVICE:

USERNAME:	NOTES:
PASSWORD:	

DEVICE:

USERNAME:	NOTES:
PASSWORD:	

DEVICE:

USERNAME:	NOTES:
PASSWORD:	

DEVICE:

USERNAME:	NOTES:
PASSWORD:	