Vermont Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will (Terminal Care Document)
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Terminal Care Document)

To my family, my physician, my lawyer, my clergyman. To any medical facility in whose care I happen to be. To any individual who may become responsible for my health, welfare, or affairs.

Death is as much a reality as birth, growth, maturity, and old age. It is the one certainty of life. If the time comes when I can no longer take part in decisions of my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which I am in a terminal state and there is no reasonable expectation of my recovery, I direct that I be allowed to die a natural death and that my life not be prolonged by extraordinary measures. I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.

This statement is made after careful consideration and is in accordance with my strong convictions and beliefs. I want the wishes and directions here expressed carried out to the extent permitted by law. Insofar as they are not legally enforceable, I hope that those to whom this will is addressed will regard themselves as morally bound by these provisions.

Copies of this request have been given to (list name[s] and address[es] of person[s] and attach additional sheets if needed):

_____ (name),
of _____ (address)

_____ (name),
of _____ (address)

_____ (name),
of _____ (address)

Selection of Health Care Agent
(Durable Power of Attorney for Health Care)

DISCLOSURE STATEMENT: THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS: Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition. Your agent therefore can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. You may attach additional pages if you need more space to complete your statement. Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had. It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. The person you appoint as agent should be someone you know and trust and must be at least eighteen (18) years old. If you appoint your health or residential care provider (e.g., your physician, or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person will have to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time. You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who will have signed copies. Your agent will not be liable for health care decisions made in good faith on your behalf. Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing. This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO (2) OR MORE QUALIFIED WITNESSES WHO MUST BOTH BE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES: The person you have designated as your agent, health or residential care provider or one (1) of their employees, spouse, lawful heirs or beneficiaries named in your will or a deed, or creditors or persons who have a claim against you.

I hereby appoint _____ (name), of _____ (address), as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent

_____ (name of individual you choose as first alternate agent)

_____ (address)

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS. **(Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining measures should be withheld, directions whether to continue or discontinue artificial nutrition and hydration, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. Attach additional pages as necessary):**

THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. **(For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may include the statement by initialing the space before the statement):**

[ ] If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity and authorize my agent to decline all treatment which is primarily intended to prolong my life, including artificial nutrition and hydration.

[ ] If I suffer a condition from which there is no reasonable prospect of regaining the ability to think and act for myself, I want care directed to my comfort and dignity and also want artificial nutrition and hydration if needed, but authorize my agent to decline all other treatment which is primarily intended to prolong my life.

[ ] I want my life sustained by any reasonable medical measures, regardless of my condition.

I hereby acknowledge that this document contains a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement. The original of this document will be kept at:

_____ (address), and the following person(s) and institution(s) will have signed copies (*list name[s] and address[es] of person[s] and attach additional pages if needed*):

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (Terminal Care Document)
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT. IF I AM IN OR IS BEING ADMITTED TO A HOSPITAL, NURSING HOME, OR RESIDENTIAL-CARE HOME, AN OMBUDSMAN, HOSPITAL REPRESENTATIVE, OR OTHER AUTHORIZED PERSON HAS PERSONALLY EXPLAINED THE DURABLE POWER OF ATTORNEY TO ME AND I UNDERSTAND ITS NATURE AND EFFECT

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. 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 _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care:

Signature of Agent _____ Date _____

Signature of Alternate _____ Date _____

Statement of Ombudsman, Hospital Representative, or Other Authorized Person

(To be signed only if the principal is in or is being admitted to a hospital, nursing home, or residential-care home.)

I declare that I have personally explained the nature and effect of this durable power of attorney to the principal and that the principal understands the same

(Sign below and insert date, printed name, and address):

Signature _____ Date _____

Printed Name _____

Address _____