State of Vermont

ADVANCE HEALTH CARE DIRECTIVE

This document may be used to make your wishes known regarding what medical treatment or care you do or do not want to receive in the event you are unable to speak for yourself. You should provide a copy to your doctor, family, and friends.

I. ADVANCE HEALTH CARE DECLARATION

I, _____, being of sound mind and legal age, willfully and voluntarily make this declaration to state my desires regarding health care treatment if I am unable to speak for myself. It is my intention that this declaration be honored by my family, my physicians, and all others who may partake in my healthcare.

II. DEFINITIONS

“Artificial nutrition and hydration” is food, supplements, or fluids provided through intravenous (IV) therapy or a feeding tube.

“Life-sustaining treatment” is any mechanical or artificial treatment, procedure, or medication that would prolong the process of dying. Examples of such treatment include antibiotics, artificial respiration, cardiopulmonary resuscitation (CPR), dialysis, transfusions, and ventilation.

“Permanent unconscious state” is a total loss of consciousness from which I am unlikely to recover in the near future. Examples include a persistent vegetative state and irreversible coma.

“Terminal condition” is an irreversible illness that will likely result in my death or a state of permanent unconsciousness from which I am unlikely to recover in the near future.

III. POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT

In the event I have a terminal condition or am in a permanent unconscious state, or am otherwise unable to speak for myself, I designate the following individual as my agent to make health care decisions for me:

Agent's Full Name

Agent's Address

City State Zip Code

Agent's Home Phone **Agent's** Other Phone

DESIGNATION OF ALTERNATE AGENT(S)

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:

First Alternate Agent's Full Name

First Alternate Agent's Address

City State Zip Code

First Alternate Agent's Home Phone **First Alternate Agent's** Other Phone

If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Second Alternate Agent's Full Name

Second Alternate Agent's Address

City State Zip Code

Second Alternate Agent's Home Phone **Second Alternate Agent's** Other Phone

AGENT'S AUTHORITY

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw life-sustaining treatment, artificial nutrition and hydration, and all other forms of health care treatment to keep me alive, except as I state here:

_____

_____

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

(PLEASE INITIAL ONE)

My agent's authority becomes effective:

_____ When I become incapacitated and cannot make health care decisions on my own.

_____ Immediately upon the effective execution of this document.

AGENT'S OBLIGATION

I direct my agent to make health care decisions for me in accordance with this documents and my other wishes to the extent known to my agent. If my wishes are unknown, my agent shall make health care decisions for me to promote in my best interests and my personal values.

HIPPA WAIVER

(PLEASE INITIAL ONE)

_____ I authorize my health care providers to release my protected health information and medical records to my agent during the period my agent's authority is effective.

_____ I DO NOT authorize my health care providers to release my protected health information and medical records to my agent.

NOMINATION OF GUARDIAN OR CONSERVATOR

If a guardian conservator needs to be appointed for me by a court, I nominate to act as conservator:

Conservator's Full Name

Conservator's Address

City State Zip Code

Conservator's Home Phone **Conservator's** Other Phone

If the person named above is not willing, able, or reasonably available to act as conservator, I nominate to act as first alternate conservator:

First Alternate Conservator's Full Name

First Alternate Conservators Address

City State Zip Code

First Alternate Conservator's Home Phone

First Alternate Conservator's Work Phone

If the persons named above are willing, able, or reasonably available to act as conservator, I nominate as second alternate conservator:

Second Alternate Conservator's Full Name

Second Alternate Conservators Address

City State Zip Code

Second Alternate Conservator's Home Phone

Second Alternate Conservator's Work Phone

IV. LIVING WILL

TERMINAL CONDITION

LIFE-SUSTAINING TREATMENT:

If I become ill and have a terminal condition:

(PLEASE INITIAL ONE)

_____ I direct that life-sustaining measures be administered to prolong my life.

_____ I DO NOT want life-sustaining measures to administered.

_____ I direct that my agent decide.

ARTIFICIAL NUTRITION AND HYDRATION:

(PLEASE INITIAL ONE)

_____ I direct that artificial nutrition and hydration be administered regardless of my condition.

_____ I DO NOT want artificial nutrition and hydration to be administered regardless of my condition.

_____ I direct that my agent decide.

PERMANENT UNCONSCIOUS STATE

LIFE-SUSTAINING TREATMENT:

If I become ill and fall into a permanent unconscious state:

(PLEASE INITIAL ONE)

_____ I direct that life-sustaining measures be administered to prolong my life.

_____ I DO NOT want life-sustaining measures to administered.

_____ I direct that my agent decide.

ARTIFICIAL NUTRITION AND HYDRATION:

(PLEASE INITIAL ONE)

_____ I direct that artificial nutrition and hydration be administered regardless of my condition.

_____ I DO NOT want artificial nutrition and hydration to be administered regardless of my condition.

_____ I direct that my agent decide.

RELIEF FROM PAIN

(PLEASE INITIAL ONE)

_____ I direct that treatment for the alleviation of pain or discomfort be administered, even if it results in the hastening of my death.

_____ I DO NOT want treatment for the alleviation of pain or discomfort be administered, even if it results in the hastening of my death.

OTHER WISHES

_____

_____

V. DONATION OF ORGANS AT DEATH

Upon my death:

(PLEASE INITIAL ONE)

_____ I give any needed organs, tissues, or parts

_____ I give the following organs, tissues or parts only: _____

for the following purposes: (INITIAL ALL THAT APPLY)

_____ therapy

_____ transplant

_____ research

_____ education

_____ other: _____

_____ I DO NOT wish to make an anatomical donation.

_____ I authorize my agent to donate all or any part of my body for any purposes my agent sees fit.

VI. FINAL ARRANGEMENTS

Upon my death, I direct that my body:

(PLEASE INITIAL ONE)

_____ be interred at _____.

_____ be cremated and placed at _____.

_____ other: _____

_____ Upon my death, I authorize my agent to organize my funeral arrangements and provide for the disposition of my body as my agent sees fit.

Other Instructions: _____

_____

VII. PRIMARY PHYSICIAN

The following physician shall be my primary physician:

Name: _____
Address: _____
Telephone Number: _____

ALTERNATE PRIMARY PHYSICIAN

If the physician above is unable to act as my primary physician, the following physician shall be my primary physician:

Name: _____
Address: _____
Telephone Number: _____

VIII. SIGNATURE

Your Signature Date

Your Name

Your Address

City State Zip Code

IX. ACKNOWLEDGMENT BY AGENT

I hereby accept and agree to serve as health care agent, and act in accordance with the principal's desires as expressed in this document or otherwise known to me.

Agent's Signature Date

First Alternate Agent's Signature Date

Second Alternate Agent's Signature Date

X. WITNESS ATTESTATION AND SIGNATURES

We declare that the principal who signed this document:

1. Is personally known to us or provided proof of identity;
2. Signed this document in our presence; and
3. Appeared to be of sound mind and free from duress or undue influence.

We are not the individual(s) appoint as the principal's agent or the health care provider or employee of the health care provider of the principal.

FIRST WITNESS

First Witness' Signature Date

First Witness' Name

First Witness' Address

City State Zip Code

SECOND WITNESS

Second Witness' Signature Date

Second Witness' Name

Second Witness' Address

City State Zip Code

ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of Vermont

County of _____

On _____ before me, _____ personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

(SEAL)