|  |  |
| --- | --- |
| State of Vermont |  |
| **DURABLE POWER OF ATTORNEY FOR HEALTH CARE** | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | |  | |
| **Principal’s** Full Name | | | **Principal’s** Date of Birth | |
|  | | | | |
| **Principal’s** Address | | | | |
|  |  | | |  |
| City | State | | | Zip Code |
|  | |  | | |
| **Principal’s** Phone Number | | **Principal’s** Email | | |

**MY HEALTH CARE AGENT**

I hereby appoint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as my health care agent to make any and all health care decisions for me, except to the extent I state otherwise in this document.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **Agent’s** Address | | | |
|  |  | |  |
| City | State | | Zip Code |
|  | |  | |
| **Agent’s** Day Phone | | **Agent’s** Evening Phone | |
|  | |  | |
| **Agent’s** Cell Phone | | **Agent’s** Email | |
|  | | | |
| **Agent’s** Relationship to Principal | | | |

If this health care agent is unavailable, unable or unwilling to do this for me, I appoint

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to be my alternate agent.

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **Alternate Agent’s**Address | | | |
|  |  | |  |
| City | State | | Zip Code |
|  | |  | |
| **Alternate Agent’s**Day Phone | | **Alternate Agent’s** Evening Phone | |
|  | |  | |
| **Alternate Agent’s**Cell Phone | | **Alternate Agent’s**Email | |
|  | | | |
| **Alternate Agent’s**Relationship to Principal | | | |

And if my alternate agent is unavailable, unable or unwilling to do this, I appoint

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as my next alternate agent.

|  |  |  |  |
| --- | --- | --- | --- |
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| **Next Alternate Agent’s**Address | | | |
|  |  | |  |
| City | State | | Zip Code |
|  | |  | |
| **Next Alternate Agent’s**Day Phone | | **Next Alternate Agent’s** Evening Phone | |
|  | |  | |
| **Next Alternate Agent’s**Cell Phone | | **Next Alternate Agent’s**Email | |
|  | | | |
| **Next Alternate Agent’s**Relationship to Principal | | | |

This durable power of attorney for health care shall take effect: (Check one)

Immediately, allowing my agent to make decisions for me right now.

When I am no longer able to make health care decisions for myself.

When the following condition or event occurs: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHERS WHO ARE OR MAY BECOME INVOLVED IN MY CARE**

My doctor or other health care clinician:

|  |  |  |
| --- | --- | --- |
|  | | |
| **Doctor’s**Full Name | | |
|  | | |
| **Doctor’s**Address | | |
|  |  |  |
| City | State | Zip Code |
|  | | |
| **Doctor’s**Phone Number | | |

Other people who ***may*** be consulted about medical decisions on my behalf: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Those who should ***not*** be consulted by my agent include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My health care agent or health care provider may give information about my condition to the following adults and minors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I need a **guardian** in the future, I ask the court to consider appointing he following person:

|  |  |  |
| --- | --- | --- |
|  | | |
| **Guardian’s**Full Name | | |
|  | | |
| **Guardian’s**Address | | |
|  |  |  |
| City | State | Zip Code |
|  | | |
| **Guardian’s**Phone Number | | |

Alternate preferred guardians: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persons I would ***not*** want to be my guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF VALUE AND GOALS**

My health care goals and general advice about how to approach medical choices are:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ORGAN AND TISSUE DONATION**

(Check one)

I do not wish to be an organ donor.

I want my agent and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Check one)

I wish that my agent make any decisions for anatomical gifts.

I wish the following person(s) to make any decisions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to donate (Check one)  any needed organs or tissues  major organs (heart, lungs, kidneys, etc.)  eye tissue such as skin and bones  major organs (hearts, lungs, kidneys, etc.) and eye tissue such as skin and bones.

(Check one)

I desire to donate my body to research or educational programs.

I do NOT desire to donate my body to research or educational programs.

**SIGNATURE AND DECLARATION**

The original of this document will be kept at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Address] and the following persons and institutions will have signed copies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I declare that this documents reflects my desires regarding my future health care (** **and organ and tissue donation), and that I am signing this document of my own free will.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Principal’s** Signature                                                                          Date

**WITNESS ACKNOWLEDGMENT**

I affirm that the principal appears to understand the nature of the document and to be free from duress or undue influence.

**First Witness**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | |
| **Witness 1** Signature | Date | | |
|  | | | |
| **Witness 1** Name | | | |
|  | | | |
| **Witness 1** Address | | | |
|  | |  |  |
| City | | State | Zip Code |

**Second Witness**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | |
| **Witness 2** Signature | Date | | |
|  | | | |
| **Witness 2** Name | | | |
|  | | | |
| **Witness 2** Address | | | |
|  | |  |  |
| City | | State | Zip Code |

**Ombudsman**

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 or other health care facility.

I affirm that:

• the maker of this document is a current patient or resident in a hospital, nursing home or residential care facility,

• I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court or hospital designee, and

• I have explained the nature and effect of this document to the principal and it appears that the principal is willingly and voluntarily executing it.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | |
| **Ombudsman**Signature | Date | | |
|  | | | |
| **Ombudsman**Name | | | |
|  | | | |
| **Ombudsman**Title/Position | | | |
|  | | | |
| **Ombudsman**Address | | | |
|  | |  |  |
| City | | State | Zip Code |
|  | |  |  |
| **Ombudsman** Phone Number | |  |  |