|  |  |
| --- | --- |
| 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.

|  |
| --- |
|  |
| **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 |  |   |