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