Appointment of a Health Care Agent

Vermont Advance Directive for Health Care Decisions

YOUR NAME | DATE OF BIRTH | DATE

ADDRESS

CITY | STATE | ZIP

Your **health care agent** can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and agrees to act as your agent. Your health care provider may NOT be your agent unless they are a relative. Your agent may **NOT** be the owner, operator, employee or contractor of a residential care facility, health care facility or correctional facility where you reside at the time your advance directive is completed.

I appoint this person to be my health care **AGENT**:

AGENT NAME | EMAIL

ADDRESS

HOME PHONE | WORK PHONE | CELL PHONE

(If you appoint **CO-AGENTS**, list them on a separate sheet of paper)

If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **ALTERNATE AGENT**:

ALTERNATE AGENT NAME | EMAIL

ADDRESS

HOME PHONE | WORK PHONE | CELL PHONE

Others who may be consulted about medical decisions on my behalf include:

Primary care provider (Physician, PA or Nurse Practitioner):

NAME | PHONE

ADDRESS

NAME | PHONE

ADDRESS

Those who should NOT be consulted include:

General Comments About My Health Care Goals:

SIGNED DECLARATION OF WISHES

You must sign this before TWO adult witnesses. The following people may not sign as witnesses: your agent(s), spouse, parents, siblings, children or grandchildren.

I declare that this document reflects my health care wishes and that I am signing this Advance Directive of my own free will.

SIGNATURE _____ DATE

I affirm that the signer appeared to understand the nature of this advance directive and to be free from duress or undue influence at the time this was signed. (Please sign and print)

FIRST WITNESS (PRINT NAME)

ADDRESS

SIGNATURE _____ DATE

SECOND WITNESS (PRINT NAME)

ADDRESS

SIGNATURE _____ DATE

If the person signing this document is being admitted to or is a current patient or resident in a hospital, nursing home or residential care home, an additional person (designated hospital explainer, patient representative, long-term care ombudsman, member of the clergy, Vermont attorney, or person designated by the Probate Division of the Superior Court) needs to confirm below that he or she has explained the nature and effect of the Advance Directive and that the patient or resident appears to understand this.

NAME

TITLE/POSITION PHONE

ADDRESS

SIGNATURE _____ DATE

The following have a copy of my Advance Directive (please check):

☐ Vermont Advance Directive Registry DATE REGISTERED:

☐ Health care agent ☐ Alternate health care agent

☐ Doctor/Provider(s):

☐ Hospital(s):

☐ Family Member(s):

CLEAR FORM