Durable Power of Attorney for Health Care Vermont

Standard Form

(Please print clearly, except where signature is required)

I, …….. of ……..……., hereby appoint …… of ……., as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions. Should the person I have appointed be unable, unwilling or unavailable to act as my health care agent, I hereby appoint

..... of …… as my *alternate agent*.

A. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS REGARDING HEALTH CARE DECISIONS. Here you may include any specific desires or limitations you feel are appropriate, such as when or what life-sustaining measures should be started or withheld; directions whether or not to use artificial nutrition and hydration; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. (If you want to include instructions about life-sustaining treatment, read Part B before filling out this section.) *(attach additional worksheets or pages as necessary)*

B. THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. For your convenience in dealing with this subject, some general statements concerning life-sustaining treatment are set forth below. IF YOU AGREE WITH ONE OF THE STATEMENTS, YOU MAY COPY IT IN THE SPACE PROVIDED ABOVE.

1. If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity, and authorize my agent to decline all treatment (including artificial nutrition and hydration) the primary purpose of which is to prolong life.

2. If I suffer a condition from which there is no reasonable prospect of regaining the ability to think and act for myself, I want care directed to my comfort and dignity and also want artificial nutrition and hydration, if needed, but authorize my agent to decline all other treatment the primary purpose of which is to prolong my life.

3. I want my life sustained by any reasonable medical measures, regardless of my condition.

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read, or had read to me, and understand the information contained in the disclosure statement. The original of this document will be held by my agent, and photocopies of the original will be given to my alternate agent and the following:

_____ _____

_____ _____

_____ _____

In witness whereof, I have hereunto signed my name this date of ……., 20….

Signature …… Date of Birth …….

Address ……

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: …….. Address: ……..

Witness: …….. Address: ……..

The following is required only if this document is being signed while the principal is in or being admitted to a hospital, nursing home or residential care home.

Statement of ombudsman, hospital representative, recognized member of the Vermont clergy, Vermont-licensed attorney or other person designated by the county Probate Court: I declare that I have personally explained the nature and effect of this durable power of attorney to the principal and that the principal understands the same.

Date: ……..

Name: …….. Address: ……..