FirstName LastName

VERMONT
HEALTH CARE DIRECTIVE

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in Vermont

After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to and health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

Designation of a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

Health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

ADVANCE DIRECTIVE

My Name: FirstName LastName	Date of Birth: 08/06/2024	Date Signed:
Address: 111 Street Address		
City: City	State: Vermont	Zip: 11111
Phone: 1111111111	Email: emailaddress@email.com	

MY HEALTH CARE AGENT

I appoint the following individual as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise in this directive:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Vermont 11111

Phone: 1111111111

Email: emailaddress@email.com

If this health care agent is unavailable, unable or unwilling to do this for me, I appoint the following individual to be my alternate agent:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Vermont 11111

Phone: 1111111111

Email: emailaddress@email.com

LIMITATIONS ON THE AUTHORITY OF HEALTH CARE AGENT

I do not wish to limit the authority of my health care agent at this time.

OTHERS WHO ARE INVOLVED IN MY CARE

My Doctor or Other Health Care Clinician: I do not wish to list my doctor or health care clinician at this time.

STATEMENT OF VALUES AND GOALS

This is what is most important to me: I do not wish to state my values and goals at this time.

END-OF-LIFE TREATMENT WISHES

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (choose all that apply):

☐ 1. I DO want all possible treatments to extend my life.

(or)

_____☑ 2. I DO NOT want my life extended by any of the following means:

_____☑ Breathing machines (ventilator or respirator)

_____☑ Tube feeding (feeding and hydration by medical means)

_____☑ Antibiotics

_____☑ Other medications whose purpose is to extend my life

☐ Other (specify): I do not wish to make other specifications at this time.

☐ 3. I want my agent to decide what other treatments I receive, including tube feeding.

_____☑ 4. I want care that preserves my dignity and that provides comfort and relief from symptoms that are bothering me.

_____☑ 5. I want pain medication to be administered to me even though this may have the unintended effect of hastening my death.

_____☑ 6. I want hospice care when it is appropriate in any setting.

_____☑ 7. I would prefer to die at home if this is possible.

☐ 8. Other Wishes and Instructions: I do not wish to leave other wishes and instructions at this time.

ORGAN AND TISSUE DONATION

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

_____☑ I wish to donate the following organs and tissue:

☐ I want my agent to make any decision for anatomical gifts

_____☑ Any needed organs or tissue

☐ The following organs and tissue only:

☐ I do not wish to be an organ donor.

MY WISHES FOR DISPOSITION OF MY BODY AFTER MY DEATH

I do not wish to leave directions for burial or disposition of my remains after death at this time.

If an autopsy is suggested following my death:

☐ I DO support having an autopsy performed.

☐ I DO NOT support having an autopsy performed.

_____☑ I would like my agent or family to decide whether to have it done.

SIGNATURES

This document must be signed and dated by me. It also must be verified by two witnesses and signed and dated when witnessed.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: _____

Date signed: _____

If I cannot sign my name, I ask the below named person to sign for me.

Signature: _____

Printed Name:_____

TWO WITNESSES

Witness One. In my presence on _____ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. The principal appeared to understand the nature of the document and to be free from duress or undue influence at the time the advance directive was signed. I certify the following:

- I am at least 18 years of age.
- I am not named as a health care agent or an alternate health care agent in this document.
- I am not the principal's spouse, parent, adult sibling, adult child, or adult grandchild.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two. In my presence on _____ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. The principal appeared to understand the nature of the document and to be free from duress or undue influence at the time the advance directive was signed. I certify the following:

- I am at least 18 years of age.
- I am not named as a health care agent or an alternate health care agent in this document.
- I am not the principal's spouse, parent, adult sibling, adult child, or adult grandchild.

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

_____

Witness Two Phone: _____