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:

NAME .....

ADDRESS .....

HOME PHONE ..... WORK PHONE .....

CELL PHONE ..... EMAIL .....

(If you appoint co-agents, list them above or 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**:

NAME .....

ADDRESS: .....

HOME PHONE ..... WORK PHONE .....

CELL PHONE ..... EMAIL .....

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.

SIGNED ..... 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) .....

SIGNATURE..... DATE.....

ADDRESS .....

SECOND WITNESS (PRINT NAME) .....

SIGNATURE..... DATE.....

ADDRESS .....

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): please include a separate sheet of paper if you need more room

....

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received:
Confirmed:

Vermont Advance Directive Registry

REGISTRATION AGREEMENT

VERMONT DEPARTMENT OF HEALTH SOURCE CODE: 53101301

1. Read the *Registration Policy*, and complete this *Registration Agreement*. Please type or print clearly. Be sure to sign and date the form.
2. Attach either a copy of your advance directive, or optionally, an *Advance Directive Locator* form which indicates only the physical location of your advance directive so that it can be retrieved.
3. Registrations MUST include a completed and signed *Registration Agreement* form, and a copy of your advance directive document.
4. MAIL to: Vermont Advance Directive Registry (VADR)
   523 Westfield Ave., PO Box 2789
   Westfield, NJ 07091-2789
5. OR FAX to: 908- 654-1919

For forms, or additional information visit: http://healthvermont.gov/vadr/ or call 1-800-548-9455

Registrant

Name: First _____ Middle _____ Last _____ Suffix ____

Gender: Male___ Female___ **Date of Birth** (MM/DD/YYYY): _____/_____/_____

Primary Mailing Address: _____ Apt # _____

City/Town: _____ **State**: _____ **Zip**: _____

Phone: Home ( ) _____-_____ Work ( ) _____-_____ Other ( ) _____-_____

Secondary Mailing Address: _____ Apt # _____

City/Town: _____ **State**: _____ **Zip**: _____

Emergency Contacts

Primary: Name _____ Relationship to Registrant: _____

Mailing Address: _____

City/Town: _____ **State**: _____ **Zip**: _____

Phone: Home ( ) _____-_____ Work/Other: ( ) _____-_____

Secondary: Name _____ Relationship to Registrant: _____

Phone: Home ( ) _____-_____ Work/Other: ( ) _____-_____

Does your advance directive make you an organ donor? (Circle one) YES NO

*I, _____ (**print name**) request that my advance directive be registered in the Vermont Advance Directive Registry, and authorize its access as allowed by Vermont law. By signing below, I acknowledge and affirm that: the information provided is accurate; I have read, understand, and agree to the terms of the Registry Registration Policy; I will safeguard my registrant identification number and wallet card from unauthorized access; and I will immediately notify the Registry in writing of changes to my registration information or advance directive. I execute this agreement voluntarily and without coercion, duress, or undue influence by any party. I understand that anyone who has access to my wallet card can use it to gain access to my documents and personal information. This authorization remains in effect until I revoke it.*

Signature of Registrant: _____ **Date**: ____/____/_____

VERMONT ADVANCE DIRECTIVE REGISTRY
REGISTRATION POLICY

An advance directive is a legal document that conveys a person's wishes regarding their health care treatment and end of life choices should they become incapacitated or otherwise unable to make those decisions. The Vermont Advance Directive Registry is a database that allows people to electronically store a copy of their advance directive document in a secure database. That database may be accessed when needed by authorized health care providers, health care facilities, residential care facilities, funeral directors, and crematory operators. For more information, visit: http://healthvermont.gov/vadr/.

1. To register an advance directive, the registrant must complete and send the *Registration Agreement* form along with a copy of the advance directive to:

   The Vermont Advance Directive Registry
   523 Westfield Ave., PO Box 2789
   Westfield, New Jersey 07091-2789.

   To register the physical location of the advance directive document, rather than the document itself, the registrant may send the *Advance Directive Locator* form instead of a copy of the advance directive. This form is downloadable from the Registry website.

2. Upon receipt of the *Registration Agreement* and attachments, the Registry will scan the advance directive (or *Advance Directive Locator* form), and store it in the database along with registrant identifying information from the *Registration Agreement*. The Registry will send a confirmation letter to the registrant along with a registration number, instructions for using the registration number to access documents at the Registry website, a wallet card, and stickers to affix to a driver's license or insurance card. The registration is not effective until receipt of the confirmation letter and registration materials is made by registrant.

3. Registrants should share the registration number from the wallet card with anyone that should have access to their advance directives: for example, the registrant's agent, family members, or physician. Anyone may access a person's advance directive using the registration number. Additionally, when the registration number is not readily available, an authorized health care provider can search the Registry for a specific person's advance directive using a registrant's personal identifying information.

4. The registrant is responsible for ensuring that:
   a. The advance directive is properly executed in accordance with the laws of the state of Vermont.
   b. The copy of the advance directive sent to the Registry, if a photocopy of the original, is correct and readable.
   c. The information in both the *Registration Agreement* and advance directive documents is accurate and up to date.
   d. The Registry is notified as soon as possible of any changes to the advance directive or registration information by completing and submitting an *Authorization to Change* form with the changes appended, or preferably, with an updated copy of the advance directive to the Registry.

5. Initial registration as well as subsequent changes and updates to the registration information or the advance directive documents are free of charge.

6. The Registration Agreement shall remain in effect until the Registry receives reliable information that the registrant is deceased, or the registrant requests in writing that the *Registration Agreement* be terminated. When the Agreement is terminated, the Registry will remove registrant's advance directive from the Registry database, and the file will no longer be accessible to providers.

7. Only the Registry can change the terms of the *Registration Agreement*.