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.

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) DATE

SIGNATURE _____

SECOND WITNESS (PRINT NAME) DATE

SIGNATURE _____

If the person signing this document is being admitted to or is a current patient in a **hospital**, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the patient appeared to understand and be free from duress or undue influence at the time of signing: *designated hospital explainer, ombudsman, mental health patient representative, recognized member of the clergy, Vermont attorney, or Probate Court designee.*

If the person signing this document is being admitted to or is a resident in a **nursing home or residential care facility**, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the resident appeared to understand and be free from duress or undue influence at the time of signing: *an ombudsman, recognized member of the clergy, Vermont attorney, Probate Court designee, designated hospital explainer, mental health patient representative, clinician not employed by the facility, or appropriately trained nursing home/residential care facility volunteer.*

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