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:

NAME | DOB | DATE

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

SECOND WITNESS (PRINT NAME)

SIGNATURE ..... DATE

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.*

The explainer as outlined above may also serve as one of the two required witnesses.

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

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

Vermont Advance Directive Registry

Registration Agreement & Authorization to Change Form

(Documents A & B per the Vermont Advance Directive Rule)

Directions

1. Read the Registration Policy on page 3 and complete the relevant sections below. Please type or print clearly.
   a. **First-time Registrants**: Complete the Required Registrant Information & Document A.
   b. **Updating an Advance Directive already on file**: Complete the Required Registrant Information & Document B.
2. Attach a signed and witnessed copy of your advance directive.
3. Registrations **must** include a completed and signed Registration Agreement or Authorization to Change form and a copy of the signed and witnessed advance directive document.
4. Once forms are completed and signed, send forms by email, mail **or** fax:

E-mail to: VADRSubmissions@usacpr.com

Or Mail to: Vermont Advance Directive Registry (VADR)
PO Box 2789
Westfield, NJ 07091-2789

Or Fax to: 908- 654-1919

For additional information visit: http://healthvermont.gov/vadr/ or call 1-888-548-9455

Required Registrant Information

Name: First _____ Middle _____ Last _____ Suffix ____

Date of Birth: __ __ /__ __ /__ __ __ __

Primary Mailing Address: _____

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

Phone Number: Primary (__ __ __) __ __ __-__ __ __ __ Other: (__ __ __) __ __ __-__ __ __ __

Would you like to be contacted by e-mail? ☐ No ☐ Yes

Email Address: _____

Secondary Mailing Address (if applicable): _____

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

Emergency Contacts

Primary: Name: _____

Relationship to Registrant: _____ Phone Number: (__ __ __) __ __ __-__ __ __ __

Secondary: Name: _____

Relationship to Registrant: _____ Phone Number: (__ __ __) __ __ __-__ __ __ __

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

NOTICE: All submissions to the Registry must include a signed and witnessed copy of the registrant's Advance Directive. This applies to both first-time submissions and updates to existing documents.

Document A: Registration Agreement

Complete this section **only** if this is your first time registering your advance directive.

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:** _____

Document B: Authorization to Change

Complete **only** if you are currently registered and making updates to an advance directive already on file with the registry.

Check the box below that applies to your submission.

☐ **Amend**: Check this box to amend your existing advance directive. Prior document history will be retained in your file.

☐ **Replace**: Check this box to replace your existing advance directive. Prior document history will not be retained in your file.

☐ **Suspend**: Check this box to temporarily inactivate all or part of your advance directive for a defined period of time.
Begin Date:_____ End Date:_____

☐ **Revoke**: Check this box to delete your advance directive from the registry. (This is a permanent removal from the Registry)

I, _____ (**print name**) certify that this form accurately represents the changes I have made, and these changes are accurate. Additionally, I authorize the changes to be reflected in the Advance Directive Registry.

Signature of Registrant: _____ **Date:**_____

VERMONT
DEPARTMENT OF HEALTH

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 document to:

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

2. Upon receipt of the Registration Agreement and attachments, the Registry will scan the advance directive 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.