医疗代理任命

佛蒙特州医疗决策预先指示

Appointment of a Health Care Agent

Vermont Advance Directive for Health Care Decisions

您的姓名 YOUR NAME　　出生日期 DATE OF BIRTH　　日期 DATE

地址 ADDRESS

城市 CITY　　州 STATE　　邮编 ZIP

当您不能或不愿意为自己做决定时，您的**医疗代理**可以为您做医疗决定。您应该选择一个您信任的人，一个理解您的意愿并同意作为您的代理的人。您的医疗提供者可能**不是**您的代理，除非他们是您的亲属。在完成您的预先指示时，您的代理可能**不是**您所居住的养老院、医疗设施或康复设施的所有者、运营商、员工或合同工。

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.

我指定此人为我的医疗**代理**：

I appoint this person to be my health care **AGENT:**

代理姓名 AGENT NAME　　电子邮件 EMAIL

地址 ADDRESS

家庭电话 HOME PHONE　　工作电话 WORK PHONE　　手机 CELL PHONE

(如果您指定**共同代理**，请另页列出)

(If you appoint **CO-AGENTS**, list them on a separate sheet of paper)

如果该代理没空、不愿意或不能作为我的代理，我指定此人为我的**候补代理**：

If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **ALTERNATE AGENT:**

候补代理姓名 ALTERNATE AGENT NAME　　电子邮件 EMAIL

地址 ADDRESS

家庭电话 HOME PHONE　　工作电话 WORK PHONE　　手机 CELL PHONE

其他可以代表我就我的医疗决定进行咨询的人包括:

Others who may be consulted about medical decisions on my behalf include:

家庭医生（内科医生、医师助理或护师）：

Primary care provider (Physician, PA or Nurse Practitioner):

姓名 NAME　　电话 PHONE

地址 ADDRESS

姓名 NAME　　电话 PHONE

地址 ADDRESS

不应咨询的人士包括：

Those who should NOT be consulted include:

姓名
NAME

出生日期
DOB

日期
DATE

关于我的医疗目标的一般评论：
General Comments About My Health Care Goals:

签署的愿望声明 / **SIGNED DECLARATION OF WISHES**
您必须在两位成年证人在场的情况下签署这份文件。以下人员**不能**作为见证人签名：
您的代理、配偶、父母、兄弟姐妹、子女或孙辈。
You must sign this in the presence of TWO adult witnesses. The following people may **not** sign as witnesses:
your agent(s), spouse, parents, siblings, children or grandchildren.

我声明，这份文件反映了我的医疗愿望，我是自愿签署这份预先指示。
I declare that this document reflects my health care wishes and that I am signing this Advance Directive of my own free will.

签名
SIGNED .....

日期
DATE

我确认，签署人理解这一预先指示的性质，并在签署时不受胁迫或不当影响。（请签名并打印）
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)

证人1（打印姓名）
WITNESS 1 (PRINT NAME)

签字
SIGNATURE .....

日期
DATE

证人2（打印姓名）
WITNESS 1 (PRINT NAME)

签字
SIGNATURE .....

日期
DATE

如果签署本文件者已入院或目前是**医院**病人，下列人员之一必须签字并确认，他们已经解释了预先指示的性质和效果，而且在签字时，病人表现出理解文件内容且没有受到胁迫或不当影响：*指定医院解释人员、监察员、心理健康病人代表、认可的神职人员、佛蒙特州律师或遗嘱检验法院指定人员。*
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.*

如果签署本文件者已入住或目前是**疗养院或养老院**的住客，下列人员之一必须签字并确认，他们已经解释了预先指示的性质和效果，而且在签字时，住客表现出理解文件内容且没有受到胁迫或不当影响：*监察员、认可的神职人员、佛蒙特州律师、遗嘱检验法院指定人员、指定医院解释人员、心理健康病人代表、非该院雇用的临床医生或经过适当培训的疗养院/养老院志愿者。*
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.*

上文所述的解释者也可以作为两个必需的证人之一。
The explainer as outlined above may also serve as one of the two required witnesses.

姓名
NAME

头衔/职位
TITLE/POSITION

电话
PHONE

地址
ADDRESS

签字
SIGNATURE .....

日期
DATE

以下是我的预先指示(请查阅)：
The following have a copy of my Advance Directive (please check):

☐ 佛蒙特州预先指示登记处
Vermont Advance Directive Registry

登记日期：
DATE REGISTERED:

☐ 医疗代理
Health care agent

☐ 候补医疗代理
Alternate health care agent

☐ 医生/提供者：
Doctor/Provider(s):

☐ 医院：
Hospital(s):

☐ 家庭成员：
Family Member(s):

明文形式
CLEAR FORM

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

佛蒙特州预先指示登记处
管理表格：VADR 登记协议及更改授权书
(根据佛蒙特州预先指示规则提供的文件A和B)

Vermont Advance Directive Registry
Administrative Form: VADR Registration Agreement & Authorization to Change
(Documents A & B per the Vermont Advance Directive Rule)

说明 / Directions

1. 请阅读**第 3 页的登记政策，**并**填写第 1 页的必填登记者信息。**
   Read the Registration Policy on page 3 and complete the Required Registrant Information on page 1.
   a. **首次登记者：**填写**文件 A：登记协议见第 2 页。**
      First-time Registrants: Complete **Document A: Registration Agreement on page 2.**
   b. **目前登记者：**如果您已登记并提交更新资料，请填写**文件 B：更改授权书见第 2 页。**
      Current Registrants: If you are already registered and submitting an update, complete **Document B: Authorization to Change on page 2.**
2. 附上一份您的预先指示的签字和见证人的副本。*预先指示的见证人不能是您的医疗代理或直系亲属（配偶、父母、子女、兄弟姐妹或孙子女）。*
   Attach a signed and witnessed copy of your Advance Directive. Witnesses to your Advance Directive cannot be your health care agent or immediate family (spouse, parents, children, siblings or grandchildren).
3. 通过邮件、电子邮件或传真提交的资料必须包括本管理表格的第 1 页和第 2 页以及您已填写的预先指示的所有页面。
   Submissions via mail, email, or fax must include pages 1 and 2 of this Administrative Form and all pages of your completed Advance Directive.
4. 填写完成后，可通过邮件、电子邮件或传真提交表格：
   Once complete, forms can be submitted via mail, email, or fax:

邮件： Mail: Vermont Ethics Network, 61 Elm Street, Suite 1, Montpelier, VT 05602

电子邮件*： Email*: VADRSupport@vtethicsnetwork.org

** 通过电子邮件提交资料的，务必使用 PDF 格式。*
** Email submissions must be in PDF format.*

传真： / Fax: 1-802-828-2646

佛蒙特州登记者现在也可以通过线上用户上传功能提交最新登记资料或更新信息。用户上传功能不需要提交此管理表格有关从家用计算机上传文件的更多信息相关和链接，请访问www.vtethicsnetwork.org/vadr。**如果您提交资料需要支持，请致电 1-802-828-2909 或发送电子邮件至VADRSupport@vtethicsnetwork.org**

Vermont registrants can now also submit new registrations or updates via on-line user upload. User upload does not require this administrative form. For more information and links to upload your document from your home computer, visit www.vtethicsnetwork.org/vadr. For support with your submission, call 1-802-828- 2909 or email VADRSupport@vtethicsnetwork.org

必要的登记者信息 / Required Registrant Information

姓名： Name: 名字 First _____ 中间名 Middle _____ 姓氏 Last _____ 词尾 Suffix ____

出生日期： Date of Birth: __ __ / __ __ / __ __ __ __ **(年/月/日)** (month/day/year)

邮寄地址： Mailing Address: _____ **公寓/单元：** Apt/Unit: _____

镇/市： Town/City: _____ **州：** State: _____ **邮编：** Zip code: _____

电话号码： Phone Number: 主要 Primary (__ __ __) __ __ __-__ __ __ __ 其它：Other: (__ __ __) __ __ __-__ __ __ __

电邮地址： Email Address: _____

*** 登记者必须提供电子邮件地址，以接收年度账户提醒。**
**** Registrants must provide an email address to receive annual account reminders.***

紧急联系人 / Emergency Contacts

如可用，请首先列示手机号码
Please list cell number first if available

主要： Primary: 姓名：Name: _____ 与登记者的关系：Relationship to Registrant: _____

电话号码：Phone Number: (__ __ __) __ __ __-__ __ __ __ 备用电话号码：Alternate Phone Number: (__ __ __) __ __ __-__ __ __ __

第二联系人*： Secondary: 姓名：Name: _____ 与登记者的关系：Relationship to Registrant: _____

电话号码：Phone Number: (__ __ __) __ __ __-__ __ __ __

** 可选 / Optional*

注：紧急联系人并不一定与您指定的医疗保健代理是同一人。变更紧急联系人不会变更您的医疗保健代理。
Note: *Emergency contacts do not need to be the same as your appointed health care agents. Changing your emergency contacts will not change your health care agent.*

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

佛蒙特州预先指示登记处
管理表格：VADR 登记协议及更改授权书
(根据佛蒙特州预先指示规则提供的文件A和B)

Vermont Advance Directive Registry
Administrative Form: VADR Registration Agreement & Authorization to Change
(Documents A & B per the Vermont Advance Directive Rule)

文件A:登记协议
Document A: Registration Agreement

如果您是首次向佛蒙特州预先指示登记处提交预先指示，请填写本部分。
Complete this section if this is your first time submitting an Advance Directive to the Vermont Advance Directive Registry.

本人 _____ **(正楷姓名)**请求在佛蒙特州预先指示登记处登记我的预先指示，并在佛蒙特州法律允许下授权其访问。本人同意并确认：所提供的信息准确无误；本人已阅读、理解并同意登记处的登记政策条款；本人将妥善保管本人的登记身份证号及钱包卡，防止他人非法访问；若本人登记资料或预先指示有任何更改，本人将立即以书面通知登记处。本人自愿签署本协议，不受任何一方的胁迫、威胁或不当影响。我理解任何可以访问我的钱包卡的人都可以用它来获取我的文件和个人信息。此授权在我撤销之前一直有效。

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.

登记者签名：
Signature of Registrant: _____ **日期：** **Date:** _____

文件B：更改授权
Document B: Authorization to Change

如果您目前已登记并提交更新后的预先指示，或拟对已在佛蒙特州预先指示登记处存档的预先指示进行更新，请填写本部分。
Complete this section if you are currently registered and submitting an updated Advance Directive or making updates to an Advance Directive already on file with the Vermont Advance Directive Registry.

勾选下面适用于您提交内容的方框。
Check the box below that applies to your submission.

☐ **替换：**勾选此框可替换现有的预先指示。此选项将从您的帐户中删除版本较旧的文档，仅保存最近提交的文档。/ **Replace:** Check this box to replace your existing Advance Directive. This option will remove older documents from your account and save only the most recent submission.

☐ **修改：**勾选此框可修改现有的预先指示。此选项将首先保存您之前的文档与最新文档（时间倒序）。/ **Amend:** Check this box to amend your existing Advance Directive. This option will keep your prior documents on file with the newest document first (reverse chronological order).

☐ **暂停：**勾选此框可在指定期间暂时停用全部或部分预先指示。
Suspend: Check this box to temporarily inactivate all or part of your Advance Directive for a specified period

开始暂停日期：
Begin suspension on this date: _____

终止暂停日期：
End suspension on this date: _____

暂停详情（预先指示暂停部分、暂停原因）：
Suspension details (parts of Advance Directive being suspended, reason for suspension):

_____

☐ **撤销：**勾选此框，从佛蒙特州预先指示登记处删除您的预先指示。您在佛蒙特州预先指示登记处的帐户将关闭，届时医疗保健机构将无法访问您的文件。您的预先指示将仍有效。
Revoke: Check this box to remove your Advance Directive from the Vermont Advance Directive Registry. Your account with the Vermont Advance Directive Registry will be closed and your document will not be accessible to health care facilities. Your Advance Directive will remain valid.

本人 _____ **(正楷姓名)**证明此表格准确地代表我所作的更改，而这些更改是准确的。此外，我授权这些更改将反映在预先指示登记处。
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.

登记者签名：
Signature of Registrant: _____ **日期：** **Date:** _____

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

登记政策 / Registration Policy

预先指示是一种法律文件，它传达一个人在丧失行为能力或因其他原因无法作出决定时，关于其医疗治疗和结束生命选择的愿望。佛蒙特州预先指示登记处是一个数据库，允许人们以电子方式将其预先指示文件副本存储在一个安全的数据库中。经授权的医疗提供者、医疗设施、养老院、丧葬承办人和火葬场经营者可在需要时访问该数据库。欲了解更多信息，请访问：http://healthvermont.gov/vadr/.

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. 如需通过邮件、传真或电子邮件登记预先指示，登记者必须填写并将登记协议表格连同预先指示文件副本发送至：
   To register an advance directive via mail, fax, or email, the registrant must complete and send the Registration Agreement form along with a copy of the advance directive document to:

   邮件：
   Mail:
   Vermont Ethics Network
   61 Elm Street, Suite 1
   Montpelier, VT 05602

   传真： / Fax: 1-802-828-2646

   电子邮件*：
   Email*: VADRSupport@vtethicsnetwork.org

   ** 通过电子邮件提交资料的，务必使用 PDF 格式。*
   ** Email submissions must be in PDF format.*

2. 通过用户上传功能上传文件的登记者无需填写《登记协议及更改表格授权书》。将在线上上传过程中，填写必要的协议并提供必要授权。
   Registrants who upload their document via user upload do not need to complete the Registration Agreement Authorization to Change form. The necessary agreements and authorization will be completed during the on- line upload process.

3. 在收到登记协议及其附件后，登记处将扫描预先指示，并将其与登记协议中的登记者识别信息一起存储在数据库中。登记处将向登记者发送一封确认函，同时附上一个登记号、使用登记号访问登记处网站文件的说明、钱包卡和贴在驾照或保险卡上的贴纸。登记者在收到确认信及登记资料后，登记即告有效。
   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.

4. 登记者应该将钱包卡上的登记号分享给任何有权访问其预先指示的人：如，登记者的代理、家庭成员或医生。任何人都可以使用登记号码访问某人的预先指示。此外，在没有登记号码的情况下，经授权的医疗提供者可以使用登记者的个人身份信息在登记处搜索特定个人的预先指示。
   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.

5. 登记者有责任确保：
   The registrant is responsible for ensuring that:
   a. 根据佛蒙特州的法律，预先指示将被妥善执行。
      The advance directive is properly executed in accordance with the laws of the state of Vermont.
   b. 如果预先指示正本的影印本是正确和可读的，则发送给登记处的副本也是正确和可读的。
      The copy of the advance directive sent to the Registry, if a photocopy of the original, is correct and readable.
   c. 登记协议和预先指示文件中的信息都是准确和最新的。
      The information in both the Registration Agreement and advance directive documents is accurate and up to date.
   d. 如预先指示或登记资料有任何更改，请填妥并提交一份附有更改的“更改授权书”表格，或最好附上预先指示的更新副本，以尽快通知登记处。
      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.

6. 首次登记以及随后对登记信息或预先指示文件的更改和更新是免费的。
   Initial registration as well as subsequent changes and updates to the registration information or the advance directive documents are free of charge.

7. 登记协议应继续有效，直至登记处收到登记者死亡的可靠信息，或登记者书面要求终止登记协议。本协议终止时，登记处将从登记处数据库中删除登记者的预先指示，提供者将无法访问该文件。
   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.

8. 只有登记处可以更改登记协议的条款。
   Only the Registry can change the terms of the Registration Agreement.