

VERMONT DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint _____ of _____ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

(a) STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining measures should be withheld; directions whether to continue or discontinue artificial nutrition and hydration; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason.

(attach additional pages as necessary)

(b) THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR

IMPORTANCE. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INCLUDE THE STATEMENT IN THE BLANK SPACE ABOVE:

If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity, and authorize my agent to decline all treatment (including artificial nutrition and hydration) the primary purpose of which is to prolong my life.

If I suffer a condition from which there is no reasonable prospect of regaining the ability to think and act for myself, I want care directed to my comfort and dignity and also want artificial nutrition and hydration if needed, but authorize my agent to decline all other treatment the primary purpose of which is to prolong my life.



I want my life sustained by any reasonable medical measures, regardless of my condition.

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____ of _____

as alternate agent.

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

The original of this document will be kept at _____

and the following persons and institutions will have signed copies:

In witness whereof, I have hereunto signed my name this _____ day of _____, 20____

Signature

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: _____ Address: _____

Witness: _____ Address: _____

Statement of ombudsman, hospital representative or other authorized person (to be signed only if the principal is in or is being admitted to a hospital, nursing home or residential care home):

I declare that I have personally explained the nature and effect of this durable power of attorney to the principal and that the principal understands the same.

Date: _____

Address: _____

Name: _____

