

# INFORMATION CONCERNING THE VERMONT STATUTORY (Durable Power of Attorney for Healthcare)

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

*Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself.*

*"Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent therefore can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment.*

*You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. You may attach additional pages if you need more space to complete your statement.*

*Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had.*

*It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.*

*The person you appoint as agent should be someone you know and trust and must be at least 18 years old. If you appoint your health or residential care provider (e.g. your physician, or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person will have to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.*

*You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who will have signed copies. Your agent will not be liable for health care decisions made in good faith on your behalf.*

*Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing.*

*This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.*

*You may wish to designate an alternate agent in the event that your agent is unwilling, unable or ineligible to act as your agent. Any alternate agent you designate will have the same authority to make health care decisions for you.*



THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO (2) OR MORE QUALIFIED WITNESSES WHO MUST BOTH BE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

- the person you have designated as your agent;
- your health or residential care provider or one of their employees;
- your spouse;
- your lawful heirs or beneficiaries named in your will or a deed;
- creditors or persons who have a claim against you.

**VERMONT STATUTORY DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

I , (print name) \_\_\_\_\_, hereby appoint (name) \_\_\_\_\_ of (address) \_\_\_\_\_ 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 (name) \_\_\_\_\_ of (address) \_\_\_\_\_ 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:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

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: .....

In the event that I, **Name (11 pt)** \_\_\_\_\_, have been determined by my physician(s) to be incapacitated to provide informed consent for medical treatment and surgical and

diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: \_\_\_\_\_ / Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (w) \_\_\_\_\_ (h) \_\_\_\_\_ (c) \_\_\_\_\_

If my surrogate is unwilling or unable to perform his duties, I wish to designate as my alternate surrogate:

Name: \_\_\_\_\_ / Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (w) \_\_\_\_\_ (h) \_\_\_\_\_ (c) \_\_\_\_\_

**Part 1 — Power of Attorney for Health Care (12 pt)**

(1.1) DESIGNATION OF AGENT (10 pt): I designate the following individual as my agent to make health care decisions for me:

Name of individual you choose as agent: \_\_\_\_\_

Relationship \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: (w) \_\_\_\_\_ (h) \_\_\_\_\_ (c) \_\_\_\_\_

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness #1: Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

Witness #2: Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

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