Vermont Advance Directive for Health Care

LONG FORM —

**Explanation and Instructions**

n Advance Directive is a document you prepare to choose someone as your health

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can include instructions about your health care as well as what should happen with your body after you die. Having an Advance Directive helps when you no longer can

or no longer wish to make your own decisions. As you begin your Advance Directive, here are some important things to know:

• You have the right to consent to or refuse any medical treatment.

• You have the right to appoint an **agent** to make decisions for you.

• You may use this Advance Directive to share your wishes ***in advance***.

• You may ﬁll out all Parts of this Advance Directive form or just portions of it. For example, you can just appoint an agent in Part 1 and then sign Part 9. If you choose not to appoint an agent, you can skip part 1 and just give instructions in other Parts that you wish to ﬁll out. However,

if you ﬁll out any Part of this document, you must also ﬁll out Part 9, as it provides signatures and witnesses to validate the Advance Directive.

• You may use any Advance Directive form or format as long as it is properly signed and wit- nessed.

• You can revoke or suspend your Advance Directive at any time unless you expressly waive your right to do so.

**Everyone could beneﬁt from having an Advance Directive** — not just those anticipating the end of their lives. Any of us could have an accident or suﬀer from an unexpected medical condi- tion. Some of us live with a mental or physical illness that leaves us without capacity at times. Without an Advance Directive, those making decisions for you will not know what your wishes are. Worse still, your family and friends could ﬁght over the care you should get. Help them help you — ﬁll out and sign an Advance Directive.

**This Advance Directive has 9 Parts.** Fill out as few or as many Parts as you like today. If you want, you can ﬁll out other Parts another day. This is *your* document: change it as you like so that it states your wishes in your own words. You may cross out what you don’t like and add what you want.

***Note: For copying and storing purposes only the actual form pages, not the instructions, have consecutive page numbers. When sending copies, you need send only the numbered pages of the form itself.***

**Updating your Advance Directive**

It is very important that the information in your Advance Directive is always current. Review it once a year or when events in your life change. Consider the “5 D’s” as times when your Advance Directive might need to be changed or updated. The 5 D’s are: Decade birthday, Diagnosis, Deterioration, Divorce or Death of somebody close to you or that aﬀects you. All of these events may aﬀect how you think about future health care decisions for yourself.

Whenever necessary, you should also update addresses and contact information for your agent and alternate agent and other people such as potential medical guardians whom you may have identiﬁed in your Advance Directive.

**Revoking or Suspending your Advance Directive**

You may revoke your Advance Directive by completing a new Advance Directive or completing replacement Parts of this Advance Directive. Then the old Advance Directive or Part is no longer in eﬀect and the new one replaces it. If the new one and the old one cover diﬀerent subjects, then both will be in eﬀect.

Suspending an Advance Directive is when you want a provision to not be in eﬀect for a period of time. For example, you may have said you wanted a DNR order and the order may have been given to you. Then you need to go in for surgery and want the understanding that you will be revived during surgery if your heart stops.

You may revoke or suspend all or part of your Advance Directive by doing any of the following things:

1. Signing a statement suspending or revoking the designation of your agent;

2. Personally informing your doctor and having him or her note that on your record;

3. Burning, tearing, or obliterating the Advance Directive either personally or at your direction when you are present; or

4. For any provision (other than designation of your agent), stating orally or in writing, or indicating by any other act of yours that your intent is to suspend or revoke any Part or statement contained in your Advance Directive.

**Instructions for Part 1**

Appointment of My Health Care Agent

**Appointing an agent to make decisions for you may be the single most important part of your Advance Directive.** Your agent must be at least 18 years old and should be someone you know and trust. The person you choose should be someone who can make decisions for you, based upon your wishes and values. You ***cannot*** appoint your doctor or other health care clini- cian to be your agent. If you are in a nursing home or residential care facility, staﬀ or owners can- not be your agents unless they are related to you. You can appoint an **alternate agent** to make decisions for you if your original agent is unavailable, unable, or unwilling to act for you. You can also appoint co-agents if you wish. (If you appoint co-agents, use the second page of Part 1 of this form.)

The authority of your agent to make decisions for you can begin:

• when you no longer have the ***capacity*** to make decisions for yourself, such as when you are unconscious or cannot communicate, or

• ***immediately*** upon signing the advance directive *if you so specify*, or

• when a ***condition*** you specify is met, such as a diagnosis of a debilitating disease such as

Alzheimer’s Disease or serious mental illness, or

• when an ***event*** occurs that you want to mark the start of your agent’s authority, such as when you move to a nursing home or other institution.

The authority of your agent will *end* when you regain capacity to make your own decisions or you may specify when you want your Advance Directive to be no longer in eﬀect.

Once your Advance Directive goes into eﬀect, your agent will have access to all your medical records and to persons providing your care. *Unless you state otherwise* in written instructions, your agent will have the same authority to make all decisions about your health care as you have.

Your agent will be obligated to follow your instructions when making decisions on your behalf to the extent that they apply. If you choose not to leave explicit written directions in other Parts of your Advance Directive, the persons making health care decisions for you will be guided by knowledge of your values and what is in your best interest at the time treatment is needed.

Advance Directive

MY NAME . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . DATE OF BIRTH . . . . . . . . . . . . . . . . . . DATE SIGNED. . . . . . . . . . . . . . . . ADDRESS . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

CITY . . STATE ZIP. . . . . . . . . . . . . . . . . . . . . . . . . . .

PHONE EMAIL . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

**Part 1: My Health Care Agent**

1. I want my agent to make decisions for me: (choose one statement below\*)

when I am no longer able to make health care decisions for myself, or

immediately, allowing my agent to make decisions for me right now, or

when the following condition or event occurs (to be determined as follows):

*\* Normally these statements are separate choices, but it is conceivable that they could be concurrent.*

2. I appoint as my health care Agent to make any and all health care decisions for me, except to the extent that I state otherwise in this Advance Directive.

(You may cross out the italicized phrase if authority is unrestricted.)

Address:

Relationship (optional):

Tel. (daytime):

cellphone:

(evening):

email:

3. If this health care agent is unavailable, unable or unwilling to do this for me, I appoint

to be my Alternate Agent.

Address:

Relationship (optional):

Tel. (daytime):

cellphone:

(evening):

email:

And if my Alternate Agent is unavailable, unable or unwilling to do this, I appoint

as my Next Alternate Agent.

Address:

Relationship (optional):

Tel. (daytime):

cellphone:

(evening):

email:

4.

I want to appoint two or more people to be co-agents and have listed them on page two of this Part.

**Appointment of “co-agents”**

You can appoint co-agents — people you ask to make decisions for you, acting together, based upon a discussion of your circumstance and agreement on a course of action or treatment. Sometimes co-agents have diﬃculty making decisions together. Before completing this part, be sure this is the best choice for you and your co-agents.

Not all of the people you ask to be co-agents may be readily available to speak for you or to make decisions that have to be made immediately, particularly in an emergency. For this reason, it is a good idea to give additional directions about how decisions can be made by your co-agents.

5. Co-agents I appoint are:

Name:

Relationship (optional):

Address:

Phone (specify work, home or cell):

Name:

Relationship (optional):

Address:

Phone (specify work, home or cell):

Name:

Relationship (optional):

Address:

Phone (specify work, home or cell):

(repeat below for additional co-agents)

6. I prefer that decisions made by the co-agents named above be made in the following way (you may choose one or prioritize 1,2,3):

by agreement of all co-agents

by a majority of those present, or

by the ﬁrst person available, if it is an emergency.

7. Other Instructions for co-agents (optional):

**Instructions for Part 2**

Others who may be involved in my care.

**Part 2** is where you can list your current doctor or clinician with address and phone number. This will help by identifying someone who knows your medical history.

You can also state who else should or should ***not*** be consulted about your care.

You can state who is to be given information about your medical condition. This list might include your children, even if they are minors, or your close friends. Hospitals are required to withhold information about your condition from people unless you or your agent gives permission that this can be shared.

You can state who shall not be able to challenge decisions about your care in court actions. Normally any “interested individual” can bring an action in Probate Court regarding decisions made on your behalf. “Interested individuals” are your spouse, adult child, parent, adult sibling, adult grandchild, reciprocal beneﬁciary, clergy person or any adult who has exhibited special care and concern for you and who is personally familiar with your values. If there is someone in that list that you do ***not*** want to be able to bring an action to protect you, you may record the name of that person in Part 2.

Sometimes a court appoints a guardian for a person who is unable to manage aspects of his per- sonal care or ﬁnancial aﬀairs. You can state a preferred person that you would like the court to appoint if this occurs in the future. That person could be the same person you chose as an agent or it could be someone else. You can also identify persons you would ***not*** want appointed as a future guardian for you.

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**Part 2: Others Who Are or May Become Involved in My Care**

|  |  |  |
| --- | --- | --- |
| 1. | My Doctor or other Health care Clinician: |  |
|  | Name: | Address: |
| Phone: | | |
|  | (or)  Name: | Address: |
| Phone: | | |

2. Other people whom my agent ***may*** be consulted about medical decisions on my behalf:

Those who should ***not*** be consulted by my agent include:

3. My health agent or health care provider may give information about my condition to the following adults and minors:

4. The person(s) named below shall NOT be entitled to bring a court action on my behalf concern- ing matters covered by this Advance Directive nor serve as a health care decision maker for me.

Name:

Address:

5. If I need a **guardian** in the future, I ask the court to consider appointing the following

person:

My health care agent

The following person:

Name:

Phone:

Address:

You may also list alternate preferred guardians, or persons that you would not want to have

appointed as guardians.

Alternate preferred guardians:

Persons I would not want to be my guardian:

**Instructions for Part 3**

Statement of Values and Goals

**Part 3** allows you to state in your own words what is most important to you as you think about medical care you may receive in the future. This will guide your agent and your health care pro- viders and will let them know why you think particular choices are important based upon your own values and beliefs.

If you choose to ﬁll out this Part, you may wish to use the **Worksheet 1: Values Questionnaire** that is in the Vermont Ethics Network booklet *Taking Steps* for help in framing and sharing your response.

You may also wish to use **Worksheet 2: Medical Situations and Treatment**. The second work- sheet helps you consider how you might respond to changing circumstances and the changing chances that medical treatment may be successful.

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**Part 3: Statement of Values and Goals**

Use the space below to state in your own words what is most important to you.

…. And general advice about how to approach medical choices depending upon your current or future state of health or the chances of success of various treatments.

**Instructions for Part 4**

End of Life Wishes.

**Part 4** contains statements that you can use to express either a desire for continued treatment or a desire to limit treatment as death approaches or when you are unconscious and unlikely to regain consciousness.

Part 4 allows you to include other things that may be important to you, such as the type of care you would want and where you hope to receive that care if you are very ill or near the end of your life.

There may be other issues about health care when death is not expected or probable. These treat- ment issues and choices you can address in Parts 5 and 6 if you wish.

There may be questions about your survival that even doctors cannot predict accurately in your case. It is important to repeat that Part 4 is for those situations where you are ***not*** likely to survive or to continue living without life-sustaining treatment on a long-term basis.

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**Part 4: End-of-Life Treatment Wishes**

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (choose all that apply):

|  |  |  |
| --- | --- | --- |
| 1. | – *or –* | I **do** want all possible treatments to extend my life. |
| 2. |  | I **do not** want my life extended by any of the following means: |
|  |  | breathing machines (ventilator or respirator) |
|  |  | tube feeding (feeding and hydration by medical means) |
|  |  | antibiotics |
|  |  | other medications whose purpose is to extend my life |
|  |  | any other means |
|  |  | Other (specify) |
| 3. |  | I want my **agent to decide** what treatments I receive, *including tube feeding* |
| 4. |  | I want care that preserves my dignity and that provides **comfort and relief** from symptoms that are bothering me. |
| 5. |  | I want **pain medication** to be administered to me even though this may have the  *unintended eﬀect* of hastening my death. |
| 6. |  | I want **hospice care** when it is appropriate in any setting. |
| 7. |  | I would prefer to **die at home** if this is possible. |

8. Other wishes and instructions: (state below or use additional pages):

**Instructions for Part 5**

Other Treatment Wishes.

**Part 5** addresses situations which may be temporary, long-term or which may be part of a health crisis that might become life ending for you if no treatment was given or if it was unsuccessful.

You may want to state your wishes regarding a **“Do Not Attempt Resuscitation” Order (DNR Order)** if your heart were to stop (statement 1). Such an order must be written and signed by

your doctor. Either the completed written order, or a special bracelet or other identiﬁcation of that order, needs to be available for any emergency ﬁrst responders who are called to the scene when your heart stops. It is up to you or your agent to make sure that these additional steps are taken, including having your doctor complete and sign the order and give you either a copy of the order or some other identiﬁcation.

You may be in a situation in which there is a chance for recovery but, without treatment, you might die. Statement 2 is about allowing a **“trial of treatment”** in situations like these. This means you want to start treatments that will sustain your life, such as breathing machines or

tube feeding, to see if you will recover. If these life sustaining treatments are not successful after a period of time, you give your agent and other care providers permission to stop or withdraw them.

Other statements in this Part concern your wishes about hospitalization and treatment as well as participation in medical student education, or clinical or drug trials as part of your treatment.

There is also a statement about mental health treatment and your preferences concerning types of involuntary treatment.

Statement 9 of this Part concerns speciﬁc directions for prescribing and conducting electro- convulsive therapy (ECT) sometimes called “electro-shock” treatment.

If certain statements of Part 5 do not concern or apply to you, do not feel you have to address them. If you have an agent, that person will make decisions for you should the need arise.

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**Part 5: Other Treatment Wishes**

1.

2.

**I wish to have a Do Not Resuscitate (DNR) Order** written for me.

If I am in a critical health crisis that may not be life-ending and **more time is needed** to determine if I can get better, I want treatments started. If, after a reasonable period of

time, it becomes clear that I will ***not*** get better, I want all life extending treatment ***stopped***.

This includes the use of breathing machines or tube feeding.

3. If I am conscious but become **unable to think or act for myself** and will likely not improve, I do

not want the following life-extending treatment:

breathing machines (ventilators or respirators)

feeding tubes (feeding and hydration by medical means)

antibiotics

other medications whose purpose is to extend life

any other treatment to extend my life

Other:

4.

5.

If the likely **costs, risks and burdens** of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are:

If it is determined that I am **pregnant** at the time this Advance Directive becomes eﬀec- tive, I want:

all life sustaining treatment. (or)

only the following life sustaining treatments:

breathing machines (ventilators or respirators)

feeding tubes (feeding and hydration by medical means)

antibiotics

other medications whose purpose is to extend life

any other treatment to extend my life

Other:

No life sustaining treatment

6. **Hospitalization** — If I need care in a **hospital or treatment facility**, the following facilities are listed in order of preference:

Hospital/Facility:

Address.:

Hospital/Facility:

Address.:

Tel:

Tel:

Reason for preference:

I would like to ***Avoid*** being treated in **the following facilities**:

Hospital/Facility:

Hospital/Facility:

Reason:

Reason:

7. **I prefer the following medications or treatments**: Use more space or additional sheets for this

section, if needed.

Avoid use of the following medications or treatments: (List medications/treatments)

Reason:

Reason:

8. Consent for **Student Education, Treatment Studies or Drug Trials**

I **do** / **do not** *(circle one)* wish to participate in student medical education.

I **do** / **do not** *(circle one)* wish to participate in treatment studies or drug trials. (or)

I authorize my agent to consent to any of the above.

9. **Mental Health Treatment**

A. **Emergency Involuntary Treatment.** If it is determined that an emergency involuntary treatment must be provided for me, I prefer these interventions in the following order:

(List by number as many as you choose. For example, 1 = ﬁrst choice; 2 = second choice, etc. You may also note the type of medication and maximum dosage.)

Medication in pill form

Liquid medication

Medication by injection

Physical restraints

Seclusion

Seclusion and physical restraints combined

Other: Reason for preferences above (optional): B. **Electro-convulsive Therapy (ECT) or “Electro-Shock Treatment”**: If my doctor thinks that

I should receive ECT and I am not legally capable of consenting to or refusing ECT, my preference

is indicated below:

I **do NOT** consent to the administration of any form of ECT.

I **consent** / **do not consent** *(circle one)* to unilateral ECT

I **consent** / **do not consent** *(circle one)* to bifrontal ECT

I **consent** / **do not consent** *(circle one)* to bilateral ECT

I **consent** (or authorize my agent to consent) to ECT as follows:

I agree to the number of treatments the attending Psychiatrist considers appropriate.

I agree to the number of treatments Dr. considers appropriate.

I agree to the number of treatments my agent considers appropriate.

I agree to no more than the following number of treatments .

Other instructions regarding the administration of ECT:

I acknowledge that I and my agent have been apprised of and will follow the uniform

informed consent procedures and the use of standard forms to indicate consent to ECT per

18 V.S.A 7408.

**Instructions for Part 6**

Waiver of Right to Request or Object to Treatment

**Part 6** is a special part that may be used by people who want their future responses to oﬀered health treatment disregarded or ignored. **You must have an agent to ﬁll out this Part.**

There may be situations in which you might be objecting to or requesting treatment but would then want your objections or requests *to be disregarded*. If you have had treatment in the past that scares you or is uncomfortable or painful you may be likely to say “no” when it is oﬀered in a future health crisis. Still, you may know that this is the only way for you to come through a bad time or even survive. You understand that it is necessary and you would want it again if you had to have it. This Part will help you let your agent, and others know what you *really* want for yourself.

Because this is signing away a basic right that all patients have (to refuse or to request treatment)

unless a court orders otherwise, you will need to give this much careful thought. You will also

have to have additional signatures and assurances at the time you ﬁll out this Part of your Advance

Directive.

If you think Part 6 could apply to you and be helpful in your situation, you need to be sure that everyone involved in your care understands that you are making this choice of your own free will and that you understand the ramiﬁcations of waiving your right either to consent or to object to treatment.

Unlike other Parts of your Advance Directive, you can revoke Part 6 ***only when you have capacity to make medical decisions*** as determined by your doctor and another clinician.

**For your agent to be able to make healthcare decisions over your objection, you must:**

\* Name your agent who is entitled to make decisions over your objection: ;

• Specify what treatments you are allowing your agent to consent to or to refuse over your objection;

• State that you either do or do not desire the speciﬁed treatment even over your objection at the time and, further, specify your wishes related to voluntary and involuntary treatment and release from that treatment or facility;

• Acknowledge in writing that you are knowingly and voluntarily waiving the right to refuse or receive speciﬁed treatment at a time of incapacity;

• Have your agent agree in writing to accept the responsibility to act over your objection;

• Have your clinician aﬃrm in writing that you appeared to understand the beneﬁts, risks, and alternatives to the proposed health care being authorized or rejected by you in this provision; and

• Have an **ombudsman, recognized member of the clergy, attorney licensed to practice in Vermont, or a probate court designee** aﬃrm in writing that he or she has explained the nature and eﬀect of this provision to you and that you appeared to understand this explanation and be free from duress or undue inﬂuence.

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**Part 6: Waiver of Right to Request or Object to Future Treatment**

I hereby give my agent the authority to consent to or refuse the following treatment(s) over my objection if I am determined by two clinicians to lack capacity to make healthcare decisions at the time such treatment is considered:

1. **I *do* want** the following treatment to be provided, even over my objection, at the time the treat- ment is oﬀered:

**I do** *not* **want** the following treatment, even over my request for that treatment, at the time the

treatment is oﬀered:

2. I give permission for my agent to agree to have me admitted to a designated hospital or treatment

facility even over my objection.

Yes No

3. I give my agent permission to agree that my release from a voluntary admission for mental health treatment may be delayed even over my objection for up to four days so that a decision can be made regarding whether I meet criteria to be involuntarily committed.

Yes No

4. I hereby aﬃrm that I am knowingly and voluntarily waiving the right to refuse or request speciﬁed treatment at a time of incapacity, and that I understand that my doctor and one other clinician

will determine whether or not I have capacity to make health care decisions at that time. I know that I can revoke this part of my Advance Directive only when I have the capacity to do so, as determined by my doctor and at least one other clinician.

Signed: , Principal Date:

*(Continued next page)*

**Acknowledgements**

**Acknowledgement by Agent** — I hereby accept the responsibility of consenting to or refusing the treatments speciﬁed above, even if to do so would be against the principal’s expressed wishes at the time treatment is considered.

Signed: *(Agent)*  and *(Alternate)*

Print names: Phone: Date:

**Acknowledgement of principal’s clinician** — I aﬃrm that the principal appears to understand

the beneﬁts, risks, and alternatives to the health care speciﬁed above that is being consented to or refused by the principal.

Signed:

Facility:

Title:

Date:

Please print name:

**Acknowledgement by persons who explain Part 6** — I, as the designated person to explain

Part 6, aﬃrm that I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court designee and that I have:

• Explained the nature and eﬀect of this Waiver of the Right to Request or Object to Treatment to the principal, and

• The principal appears both to understand the nature and eﬀect of this provision and to be free from duress or undue inﬂuence.

• If the principal is in a hospital at the time of signing, that I am not aﬃliated with that hospital, and

• I am not related to the principal, a reciprocal beneﬁciary, or the principal’s clergy or a person who has exhibited special care and concern for the principal.

Signed:

Position:

Date:

**Instructions for Part 7**

Organ and Tissue Donation

**Part 7** of your Advance Directive allows you to state your wishes about organ and tissue donation. In our country permission for organ donation is not assumed and often the family or next of kin

are approached for donation at the time of an accidental or unexpected death. Although you may elect to have an agent or your family decide on organ and tissue donation, your organs are more likely to be used if you make the decision yourself.

You may also note your wishes on your license and attach the sticker showing that you wish to be an organ donor. You do not have to have an Advance Directive form ﬁlled out to show evidence of your wishes to be an organ donor, particularly if your license identiﬁcation includes your wishes about organ donation.

If you wish to donate your body for research to a medical school you will ﬁrst need to contact that institution to make separate arrangements and ﬁll out forms supplied by that institution.

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**Part 7: Organ and Tissue Donation**

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. *(Initial below all that apply.)*

I wish to donate the following organs and tissues:

any needed organs or tissues

major organs (heart, lungs, kidneys, etc.)

tissues such as skin and bones

eye tissue such as corneas

I wish my agent to make any decisions for anatomical gifts (or)

I wish the following person(s) to make any decisions:

I desire to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a Medical School or other program.)

I do not wish to be an organ donor.

**Instructions for Part 8**

Disposition of My Body after Death

**Part 8** allows you to give directions about funeral arrangements or related wishes about the ﬁnal disposition of your body after you die.

You can use the section to appoint an agent for making these arrangements, or you may say that family members should decide. You can give directions to whoever is in charge.

You can list important information about any pre-need arrangements you have made with a funeral home or cremation service or about the location of family burial plots.

You may indicate your permission to have an autopsy done on your body after your death. An autopsy is generally not suggested or needed when the cause of death is clear. If an autopsy

is suggested, it could be helpful to your agent or family to know your wishes about having an autopsy performed. Autopsies may be *required* in cases where abuse, neglect, suicide or foul play is suspected.

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**Part 8: My Wishes for Disposition of my Body after my Death**

1. My Directions for Burial or Disposition of My Remains after Death.

I want a funeral followed by burial in a casket at the *following location, if possible*

(please tell us where the burial plot is located and whether it has been pre-purchased):

(or)

I want to be cremated and want my ashes buried or distributed as follows:

(or)

I want to have arrangements made at the direction of my agent or family.

Other instructions:

*(For example, you may include contact information for Medical School programs if you have made arrangements to donate your body for research or education.)*

2. **Agent** for disposition of my body *(select one)*:

I want my **health care agent** to decide arrangements after my death;

if he or she is not available, I want my alternate agent to decide.

I appoint the following person to decide about and arrange for the disposition of my body after my death:

Name: Address: Telephone:

Cellphone:

(or)

I want my family to decide.

Email:

3. If an **autopsy** is suggested following my death:

I support having an autopsy performed.

I would like my agent or family to decide whether to have it done.

4. I have already made **funeral r cremation arrangements** with:

Name: Address: Telephone:

**Instructions for Part 9**

Signature and Witnesses

Congratulations! You have done much good work in sharing your wishes through the completion of your Advance Directive.

Be sure that your wishes as stated in the Parts you have chosen to ﬁll out make sense when read together as a whole. If there is a question of conﬂicting wishes, be sure that you have indicated your priorities.

When you sign your Advance Directive, you must have **two adult witnesses**. Neither witness can be your spouse, agent, brother, sister, child, grandchild or reciprocal beneﬁciary. A change in Vermont law has made it a little easier to have witnesses available to assist you. For example, your health care or residential care provider and their staﬀ now can be witnesses of Advance Directives.

If you are in a hospital, nursing home or residential care facility when you complete your Advance Directive, you will need a third person’s signature to certify that he or she has explained the Advance Directive to you and that you understand the impact and eﬀect of what you are doing. In a health care facility, this third person may be a hospital designee, a long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson or a Probate Court designee. (Note: If you decide to include **Part 6** when you are in a health care facility, you must be sure that the third person who signs your document in that Part is not aﬃliated with or employed by the health care facility.)

**Distribution of Copies of this Document**

It is a good idea to make sure that your agent, your family, your personal physician and your near- est hospital or medical facility all have copies of this Advance Directive. List the people to whom you give copies at the end of Part 9 of the Advance Directive form. This will be make it easy for you to remember to tell all of these people if you decide to cancel, revoke or change this docu- ment in the future.

By mid-2007 you will also have the option to have your advance directive scanned into an electronic databank called an **Advance Directive Registry** where you, your agent, your health care facility and others you designate, can get copies of your advance directive (including special personal handwritten instructions) immediately.

NAME DOB DATE

**Part 9: Signed Declaration of Wishes**

**I declare that this document reﬂects my desires regarding my future health care, (organ and tissue donation and disposition of my body after death,) and that I am signing this Advance Directive of my own free will.**

Signed:

Date:

*(Optional)* I aﬃrm that I have given or will give copies of my Advance Directive to my Agent(s)

and Alternate Agent(s) and that they have agreed to serve in that role if called upon to do so.

Signed:

Date:

*(Optional)* I aﬃrm that I have given or will give a copy of my Advance Directive to my Doctor or

Clinician.

Signed:

Date:

**Acknowledgement of Witnesses** — I aﬃrm that the Principal appears to understand the nature

of an Advance Directive and to be free from duress or undue inﬂuence.

Signed:

Date:

Print Name:

Signed:

Date:

Print Name:

**Acknowledgement by the person who explained this Advance Directive if the principal is a**

**current patient or resident in a *hospital, or other health care facility.***

I aﬃrm that:

• the maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,

• I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in

Vermont, or a probate court or hospital designee, and

• I have explained the nature and eﬀect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Name: Title/position:

Address:

Tel.:

Date:

***Important!***

Please list below the people and locations that will have a copy of this document:

**Vermont Advance Directive Registry** (anticipated available by mid- 2007)

**Health care agent(s)**

**Alternate health care agent**

**Family members:** (List by name all who have copies)

Name

Address

Name

Address

Name

Address

Name

Address

Name

Address

MD (Name) Address

Hospital (s) (Names)

Other individuals or locations: