

Living Will Sample Vermont (aka "Advanced Medical Directive")

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ADVANCE MEDICAL DIRECTIVE AND POWER OF ATTORNEY FOR HEALTH CARE GIVEN BY JAMES ROBERT HEDGES

INFORMATION CONCERNING THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE

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.

PART 1 POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me: **Sara Jane Hedges** whose residence is 1212 Holiday Drive, Louisville, KY.

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including those forms of health care necessary to keep me alive. Furthermore, the authority I give my agent shall include decisions to provide, withhold, or withdraw artificial nutrition. The power of my agent granted herein shall not be affected by my subsequent incapacity.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and documented in my medical records that I am either terminally ill **or** that I am in a state of persistent unconsciousness with no reasonable expectation of recovery.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care and any instructions I give in Part 2 of this form. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2 INSTRUCTIONS FOR HEALTH CARE

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration, I express to my physician, family and friends my intent.

(6) END-OF-LIFE DECISIONS: In cases where both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and document in my medical records that I am either terminally ill or that I am in a state of persistent unconsciousness with no reasonable expectation of recovery, I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have stated below. The word "Withhold" shall be used to mean both withholding the treatment if it has not yet been given and withdrawing the treatment if it is currently being administered.

* Artificially supplied nutrition and hydration (including tube feeding or food and water)	Withhold
* Surgery or other invasive procedures (i.e., those where medical instruments must enter the body)	Withhold
* Heart-lung resuscitation (CPR)	Withhold
* Antibiotics	Do NOT Withhold
* Kidney or Renal dialysis	Withhold
* Mechanical ventilator (respirator)	Withhold
* Chemotherapy and other radiation therapy	Withhold
* All other "life sustaining" medical procedures that are merely intended to keep me alive without reasonable hope of improving my condition	Withhold

I hereby acknowledge the above choices:

JAMES ROBERT HEDGES

Declarant / Principal

(7) RELIEF FROM PAIN: I direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

(8) HIPAA Privacy Authorization. I hereby authorize my Agent to execute any form authorization for use or disclosure of my Protected Health Information relating to past, present or future medical records required by the Health Insurance Portability and Accountability Act ("HIPAA"). My Agent is authorized to execute a HIPAA form authorization for release of my medical records in favor of any health provider or other party that the Agent deems appropriate.

**PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)**

(10) ORGAN DONATION: Upon my death, I wish to donate any and all of my organs, tissues, or other bodily parts for use in transplant to another human being. I authorize my health care agent to give consent to the medical organization of his choosing for donation of my aforementioned body parts.

**PART 4
PRIMARY PHYSICIAN**

(OPTIONAL)

(11) DESIGNATION OF PHYSICIAN: I designate the following physician as my primary physician: John Paul Jones, MD.

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) DURABILITY OF HEALTH CARE AGENT'S POWERS: This Health Care Power of Attorney is a durable power of attorney and the authority of my agent shall not terminate if I become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive. If I have also executed a durable financial power of attorney, this document is not meant to override that document. My health care agent's powers only extend to health care decisions as outlined in this document.

(14) DEFINITIONS:

"Artificially Provided Nutrition and Hydration" means feeding a patient through a means that is not natural such as (1) intravenously (i.e., inserting a needle directly into a patient's veins through which food or water would be forced into the patient's blood stream) or (2) a feeding tube inserted in the nose or mouth through which food or water would be forced into an individual's stomach. Assisted feeding, such as by a spoon or bottle, where the patient actively participates in the feeding process by chewing or swallowing is not considered "artificially provided nutrition and hydration".

"Persistently Unconscious" means a condition that, to a reasonable degree of medical certainty: (a) will last permanently without improvement, (b) one in which cognitive thought, purposeful action, and awareness of self and environment are absent, and (c) which has existed for a period of time sufficient, in accordance with applicable medical standards, to make a diagnosis called for in parts (a) and (b) hereof.

"Terminally Ill" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, to a reasonable degree of medical certainty, result in death within a relatively short time.

"Life-Sustaining Treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to the patient, would serve only to prolong the dying process where the patient has a terminal illness or injury, or would serve only to maintain the patient in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, surgery, chemotherapy, CPR, dialysis, use of mechanical respirators, blood transfusions, and the administration of all drugs and antibiotics (except those intended to ease pain).

SPECIAL CERTIFICATION REQUIREMENT

The following statement is required to be signed only if the principal is in or is being admitted to a hospital, nursing home or residential care home.

Statement of Ombudsman, Hospital Representative or ther authorized person

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: March ____, 2007

Signature

PRINT NAME:

PRINT ADDRESS:

(Note: This page is **not** to be attached to your Health Care Directive.)

INSTRUCTIONS REGARDING EXECUTION OF YOUR HEALTH CARE DIRECTIVE AND MEDICAL POWER OF ATTORNEY

- A. Please remember to fill in your social security number below your name on the signature page.
- B. **Please note that the principal's signature is required on pages 3 and 5 of this document.**
- C. We recommend that you execute two originals of your Health Care Directive. Give the first original to the Health Care Agent you named and you retain the second original in your home in place known to family members. If you currently under medical care for a serious medical condition, we also suggest you execute a third original and give it to your primary physician.
- D. **Witnesses.** We have written this health care directive to be valid in all 49 states (and the District of Columbia) whose laws allow for this type of document. There are varying rules among the states regarding what types of persons cannot witness a health care directive. As such, we have included with our form all the prohibitions against witness from the across the country making the list somewhat length. The following persons cannot act as a witness to a health care directive:
1. A health care provider for Declarant,
 2. An employee of a health care provider for Declarant,
 3. The operator or employee of a community or long-term care facility,
 4. Patient in a health care facility in which declarant is a patient,
 5. Individual with a claim against Declarant's estate,
 6. Individual who has a financial responsibility for Declarant's medical care, and
 7. Individual related by blood, marriage, or adoption to Declarant.
- Also, the health care agent should not be one of the witnesses to this document.** The two witnesses need to be physically present when you sign the health care directive and attest to the fact that they saw you sign the document. If you have the document notarized, the witnesses will need to be with you in front of the notary.
- E. Where do I get a notary? Your local bank is the best place to find a notary. If you cannot find a notary at your bank, please consult your local Yellow Pages which has them listed under "notaries public".
- F. Notice: This form is not intended for use in the State of Wisconsin.
- G. What if I decide to make changes to my document? We will keep your responses to the online questionnaire in our database **for 60 days after the date of purchase**. During this time, you may go to the User Administration section of our site to call up your form questionnaire and make changes—the URL is <https://www.medlawplus.com/user/>. You shall need your "user name" and "password" to re-enter the system. Once in the User Administration area, click on the text link to your form questionnaire which is located on the upper-left of the page. Make the desired changes to your responses in the questionnaire and submit to create a revised document. If you have problems calling up your old data, email us at administrator@medlawplus.com. We do our best to give a prompt response to all inquiries, usually within a few hours. NOTE: Upon registration, our system emailed to you our record of your "user name" and "password".

DISCLAIMER

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