Vermont Living Will

18 V.S.A. § 5253

To my family, my physician, my lawyer, my clergyman. To any medical facility in whose care I happen to be. To any individual who may become responsible for my health, welfare or affairs.

Death is as much a reality as birth, growth, maturity and old age-it is the one certainty of life. If the time comes when I, _____, can no longer take part in decisions of my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which I am in a terminal state and there is no reasonable expectation of my recovery, I direct that I be allowed to die a natural death and that my life not be prolonged by extraordinary measures. I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.

This statement is made after careful consideration and is in accordance with my strong convictions and beliefs. I want the wishes and directions here expressed carried out to the extent permitted by law. Insofar as they are not legally enforceable, I hope that those to whom this will is addressed will regard themselves as morally bound by these provisions.

Signed: _____

Date: _____

Witness: _____

Witness: _____

Copies of this request have been given to:

_____

_____

_____

Vermont Durable Power of Attorney for Healthcare

1. I, _____,
(name of principal)
hereby appoint _____
(name of agent)
of _____
(address and telephone number of agent)
as my agent to make any and all healthcare decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for healthcare shall take effect in the event I become unable to make my own healthcare decisions.

(a) **STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTHCARE 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 healthcare agent, I hereby appoint

_____
(name of alternate agent)

of _____
(address and telephone number of alternate agent)

as my 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 _____.
(date) *(month)* *(year)*

_____
(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 healthcare 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.

Name: _____ Date: _____

Address: _____

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