

Advance Directive for Health Care

(Vermont Statutes Annotated title 18, §§ 9700 to 9720)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent in case of my incapacity.
2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.
3. **Regarding end-of-life matters:** [initial one of the two choices]
 - (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.
 - (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.
4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

5. I give no one (including my agent) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.
6. Apart from the matters covered above, I appoint the person named herein as my agent to make health-care decisions for me. I give my agent full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed agent is unavailable, unable, or unwilling to serve, I appoint an alternate agent herein to serve with the same power and authority. I declare that this document reflects my health-care wishes and that I am signing this Advance Directive for Health Care of my own free will.

(Signature*)

(Date)

(Address)

STATEMENT OF WITNESSES: I affirm that the principal (the person who signed on page 1) appears to understand the nature of this document and that the principal appears to be of sound mind and free from duress or undue influence at the time he or she signed this document. I am 18 years of age or older. **I am not the principal's (1) health-care agent or alternate agent, (2) spouse, (3) parent, (4) adult sibling, (5) adult child, or (6) adult grandchild.**

(Signature of witness / Date)

(Signature of witness / Date)

(Address)

(Address)

THE FOLLOWING STATEMENT IS TO BE SIGNED ONLY IF THE PRINCIPAL IS IN, OR IS BEING ADMITTED TO, A HOSPITAL, NURSING HOME, OR RESIDENTIAL-CARE FACILITY:

Statement of Ombudsman, Patient Representative, Attorney, or Other Authorized Person

I affirm that I have personally explained the nature and effect of this Advance Directive for Health Care to the principal and that it appears the principal is executing it willingly and voluntarily.

(Signature of authorized person / Title / Date)

(Address)

HEALTH-CARE AGENT*

Name: _____

Address: _____

Telephone(s): _____

ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

Telephone(s): _____

*** Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care agents). You should sign this document in the presence of two witnesses. You may appoint any adult to be your agent except (1) your health-care provider, or (2) a nonrelative owner, operator, employee, agent, or contractor of a residential-care facility, a health-care facility, or a correctional facility in which you reside at the time of executing this document. A “nonrelative” is a person who is not related to you by blood, marriage, or adoption.

Advance Directive for Health Care
(signed document inside)

NO BLOOD

