VERMONT ADVANCE HEALTHCARE DIRECTIVE

MEDICAL POWER OF ATTORNEY

I. Principal

I, _____ born on _____ residing at _____ hereby designate the following individual as my agent to make medical decisions on my behalf:

II. Agent Information

Agent Name: _____

Relationship to Principal: _____

Agent Address: _____

Agent Phone Number: _____

III. Grant of Authority

I grant my agent the authority to make all medical decisions on my behalf, including but not limited to:

1. Consent to or refuse any medical treatment.

2. Access my medical records.

3. Make decisions about my care, including but not limited to hospitalization, surgery, and other medical procedures.

4. Make end-of-life decisions in accordance with my wishes.

IV. Effective Date

This Medical Power of Attorney shall become effective immediately and shall remain in effect until revoked by me in writing or until my death.

V. Revocation of Prior Documents

This document revokes any prior Medical Power of Attorney executed by the Principal.

VI. Signatures

Principal Signature: _____

Date: _____

Agent Signature (optional): _____

Date: _____

Witness Signature: _____

Print Name: _____

Date: _____

VII. Notarization

State of _____

County of _____

Subscribed, sworn to, and acknowledged before me by _____ on this _____ day of _____, _____.

Notary Public Signature: _____

Notary Public Name (Printed): _____

My Commission Expires: _____