Vermont Catholic Advance Directive

MY NAME ……..……...… DATE OF BIRTH ……... DATE ……...…..

ADDRESS.……...…

CITY……..……...….STATE …… ZIP ……...…..

PHONE ……..……CELL PHONE.…… EMAIL.……..……

This document must be signed and dated in the presence of two adult witnesses who have initialed the bottom of each page. The following people may not sign as witnesses: your agent(s), spouse, reciprocal beneficiary, children or grandchildren, parents or siblings. ***Each page of the VCAD must be signed and initialed.***

Completed copies of this form should be given to all specified agents listed below, your primary physician, family members involved in your care, and any health care facility at which you reside or are likely to receive care.

Appointment of My Health Care Agent

I instruct my Health Care Agent to act in accordance with Catholic teaching in all decisions regarding my health care. My Health Care Agent should make any and all health care decisions for me in the event I am determined to lack capacity by my physician, for the duration of my incapacity.

I appoint this person to be my Health Care Agent:

NAME …… HOME PHONE ……...……

ADDRESS ……...…….....……..

CELL PHONE …… WORK PHONE ……...……

If the person is unavailable or unable to act as my health care agent, I appoint the following person(s) to act on my behalf. These individuals have agreed to represent me in this capacity.

Alternate Agent I:

NAME ……..……...…. HOME PHONE ……..……....…….

ADDRESS ……...……

CELL PHONE ……...……. WORK PHONE ……....……..

Alternate Agent II:

NAME ……..……..……. HOME PHONE ……....…..……..……

ADDRESS ……..

CELL PHONE ……..…… WORK PHONE ……..

Signature_____ **Date**_____ **Initials of Witness 1**_____ **Witness 2**_____

VERMONT CATHOLIC ADVANCE DIRECTIVE

Instructions for My Health Care

My Catholic faith teaches that all human life is a precious gift from God from the first moment of conception to the moment of natural death, and that euthanasia and assisted suicide are not morally permissible. Therefore, I oppose any action or inaction that is intended to cause my death.

- ☑ **I always wish to receive basic care, which will allow me to be most comfortable including food, water, and pain control. I have discussed my desires regarding pain control with my agent.**

- ☑ **I wish to receive medical care and treatment appropriate to my condition as long as it is useful and offers a reasonable hope of benefit and is not excessively burdensome to me, i.e., does not impose serious risk, or some other extreme burden.**

- ☑ **If I am unable to eat and drink on my own, nutrition and hydration administered by medical means should be provided to me unless death is inevitable and imminent so that the effort to sustain my life is futile, or unless I am unable to assimilate food or fluids. "The administration of water and food, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality."** (*Bl. Pope John Paul II, to the Participants to the International Congress "Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas", March 2003*)

- ☑ **I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age, physical or mental disability, or the "quality" of my life.**

- ☑ **If my death from a terminal illness is imminent, I wish to refuse treatment that would only secure a precarious and burdensome prolongation of my life. I wish to be attended to by a Catholic priest, receive the Sacraments of Reconciliation and Anointing of the Sick and Viaticum.**

- ☑ **If I am pregnant, I wish every means to be taken to preserve and nurture the life of my unborn child, including the continuation of life-sustaining procedures for myself, if these measures could sustain the life of my unborn child until birth.**

Other considerations or wishes for my care include:

Signature_____ **Date**_____ **Initials of Witness 1**_____ **Witness 2**_____

VERMONT CATHOLIC ADVANCE DIRECTIVE

Disposition of Remains; Funeral Goods and Services

To relieve my family of the burden of making multiple decisions regarding my funeral, I am recording my wishes. I understand that the cost for the disposition of my remains and funeral services may be paid in advance through a specific funeral home, or may be paid after my death through my estate.

I, _____, designate and appoint as my agent for disposition
(PRINT NAME)
of remains and funeral goods and services:

AGENT NAME ……..…….....HOME PHONE.……...……...……..

ADDRESS ……...……

CELL PHONE …… WORK PHONE ……...

If the above-mentioned agent is unavailable or unable to act, the following alternate agent is also aware of my wishes.

AGENT NAME ……...……...……...…… HOME PHONE.……...……...……..

ADDRESS ……...……...……...

CELL PHONE ……WORK PHONE ……...…...……..

My Parish affiliation is ……..……..……
☑ **I want my funeral to include the Catholic Mass of Christian Burial at this Parish.**

Burial should be made in the ……..… (*Name of the Cemetery*)

☐ **I have a family plot and would like to be buried beside** ……..…**position #** ……..…

☐ OR **I have no plot but still wish to be buried in this cemetery.**

My agent and I have discussed the following *(please check the appropriate box)***:**

☐ **I would like to donate my organs.**

☐ **I do not want to donate my organs.**

☐ **I would like to donate my non-vital organs.**

☐ **I have already made arrangements for my funeral with the** *(Name funeral home)***:**
……..……

☐ OR **The funeral home I wish to care for my arrangements is** *(Name funeral home)***:**
……...……

☐ **I would like my body to be cremated with burial to follow.**

☐ **I would like an open casket if it is possible.**

☐ **I do not want an open casket.**

Signature_____ Date_____ Initials of Witness 1_____ Witness 2_____

VERMONT CATHOLIC ADVANCE DIRECTIVE

This Vermont Catholic Advance Directive on Health Care reflects my health care wishes, and I am signing this document of my own free will.

NAME ……...……...

SIGNED_____ DATE ……....…….

I affirm that the signer of this document appears to understand the nature of the document and to be free from duress or undue influence at the time of signing. *(Please sign and print)*

FIRST WITNESS (PRINT NAME) ……...……

(SIGNATURE) _____ DATE.……...……....

ADDRESS ……...……

SECOND WITNESS (PRINT NAME) ……...……

(SIGNATURE)_____ DATE...……...……...…

ADDRESS ……...…….

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*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, member of the clergy, Vermont attorney, or person designated by the probate court:

I declare that I have personally explained the nature and effect of this Vermont Catholic Advance Directive on Health Care to the principal, and that the principal understands the same.

NAME ……...……..

TITLE/POSITION.……...……....

ADDRESS ……....……...……...

(SIGNATURE) _____ DATE.……...……....

Signature_____ **Date**_____ **Initials of Witness 1**_____ **Witness 2**_____