ADVANCE DIRECTIVE

This document contains two parts. Both parts are for use when you can no longer communicate your health care wishes to your doctors. You may choose to sign one or the other or both.

The first form is called a Health Care Directive, also known as a **Living Will**. The Health Care Directive allows you to tell your health care providers your preferences for end of life treatment.

The second form is called a **Health Care Power of Attorney**. This Health Care Power of Attorney allows you to appoint another person to make health care decisions on your behalf taking into account your wishes.

This form was completed and signed on 3rd day of October 2025.

1. HEALTH CARE DIRECTIVE (LIVING WILL)

(If you do not wish to fill out this form and just wish to designate a health care agent, draw an "X" through the following section)

I, Bill Clayton, with a street address of 12 Baker Lane, City of Waterbury, County of Washington, State of Vermont, with the last four (4) digits of my social security number (SSN) being XXX - XX - 1234 (Hereinafter may be referred to as the 'Principal') desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

A. LIFE SUPPORT

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

BC ☒ - Chronic coma or persistent vegetative state

BC ☒ - no longer able to communicate my needs

BC ☒ - no longer able to recognize family or friends

_____ ☐ - total dependence on others for daily care

_____ ☐ - Other: _____.

Initial and check only one:

_____ ☐ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

__BC__ ☒ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

B. CERTAIN LIFE-SUSTAINING TREATMENT: (You do not have to initial and check any of these if you do not wish to)

Some people do not wish to have certain life sustaining treatments under any circumstance, even if recovery is a possibility. Check treatments below, if any, that you **do not** wish to have under any circumstances:

_____ ☐ - Cardiopulmonary Resuscitation (CPR)

_____ ☐ - Ventilation (breathing machine)

__BC__ ☒ - Feeding tube

__BC__ ☒ - Dialysis

_____ ☐ - Other: _____.

C. END OF LIFE WISHES (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that: I am brought home from the hospital to my home. I would like my family and close friends to be by my side when I pass. I prefer to have no funeral, and be cremated upon my death.

_____

_____

_____

_____

_____.

2. HEALTH CARE (MEDICAL) POWER OF ATTORNEY WITH MENTAL HEALTH AUTHORITY

It provides peace of mind to be able to choose someone you know and who knows you to make healthcare decisions on your behalf when you no longer can communicate your wishes. It is important that you discuss your wishes with your health care agent so they can be sure to make sure your wishes are carried out by the health care providers. If you DO NOT, however, choose someone to make decisions for you, write NONE in the line for the agent's name.

I, Bill Clayton, as Principal, designate Francis Sheridan as my agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations and related health care. This power of attorney is effective at the point when I am not longer able to communicate my health care wishes. My agent's decisions under this power of attorney, during any period when I am unable to make and/or communicate my health care decisions or when there is uncertainty as to whether I am dead or alive, are binding on my heirs, devisees and personal representatives.

_____ I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician. (Initial if this is your choice)

___BC___ This Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated. (Initial if this is your choice)

My **agent's** address and phone number are as follows:

55 Successor Lane, South Royalton, Vermont 05068 (802) 222-3344
Address Phone Number

If my agent is unwilling or unable to serve, I hereby appoint, Jemma Spencer as my successor agent.

My **successor agent's** address and phone number are as follows:

55 Successor Lane, South Royalton, Vermont 05068 (802) 111-2233
Address Phone Number

I intend for my agent to receive any and all of my health records and information as if I were the one requesting such information. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D and 45 CFR 160-164.

I have signed this document on this 3rd day of October 2025.

Bill Clayton
Principal's Signature

Bill Clayton
Print Name

12 Baker Lane, Waterbury, Vermont 05671
Address

(802) 333-4455
Phone Number

*You may either choose **two witnesses** or a **notary** to witness and acknowledge your signature.*

WITNESS ACKNOWLEDGMENT

On the date set forth above, I hereby state as follows:

The above named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and I am not an agent or successor agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

WITNESS 1

Carlie Sparrow
Signature

Carlie Sparrow
Print Name

5 Signer St, Norwich, Vermont 05101
Address

(802) 123-4567
Phone Number

WITNESS 2

Mitchel Roach
Signature

Mitchel Roach
Print Name

2 Signer Ave, Oaklawn, Vermont 05055
Address

(802) 765-4321
Phone Number

NOTARY ACKNOWLEDGMENT

State of _____ }

County of _____ }

Signed and sw day of _____, 20____.

I, the undersigned a aid State, hereby certify that the Principal _____ in this living will, and who is known to me, acknowledged before me of the contents of the said document, (s)he executed the same volunta e.

Given under my hand this ____ day of _____,

To be completed by a Notary Public ONLY

Notary Public Signature: _____

Printed Name: _____

My commission expires: _____

(Notary Seal)