

Vermont Advance Directive Registry PROVIDER ACCESS APPLICATION

Complete and send to:

**Vermont Department of Health
Vermont Advance Directive Registry
108 Cherry Street, PO Box 70
Burlington, VT 05402-0070**

Name of Organization: _____

Mailing Address: _____

Town/City: _____ Zip Code: _____

Main telephone: (____) _____ Fax: (____) _____

Secure Fax number(s) for back-up system to receive documents if Internet is not functioning:

(____) _____ Location of Fax machine: _____

(____) _____ Location of Fax machine: _____

Type of organization (check one):

- Healthcare provider
- Procurement organization
- Funeral & crematory services
- Other, describe _____

Please provide an Administrative Contact -- the person who will manage overall implementation of advance directive protocols in your organization, and Network/Computer Systems Contact -- the person responsible for network security, user accounts and passwords, and computer services within the organization.

Name of Administrative Contact: _____

Phone: (____) _____ E-mail address: _____

Name of Network/Computer Systems Contact: _____

Phone: (____) _____ E-mail address: _____