INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR HEALTH CARE REP.

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR FIRST ALTERNATE HEALTH CARE REPRESENTATIVE

NEW JERSEY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE

I, _____,
(name)

hereby appoint: _____
(name of health care representative)

_____
(address of health care representative)

_____ _____
(home phone number *(work phone number)*

to be my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining treatment. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, or if a situation arises that I did not anticipate, my health care representative is authorized to make decisions in my best interests.

If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the following order of priority:

1. Name _____

Address _____

City _____ State _____

Telephone _____

PRINT THE NAME, ADRESS AND TELEPHONE NUMBER OF YOUR SECOND ALTERNATE HEALTH CARE REPRESENTA-TIVE

2. Name _____

Address _____

City _____ State _____

Telephone _____

ADD PERSONAL INSTRUCTIONS (IF ANY)

I direct that my health care representative comply with the following instructions and/or limitations (optional):

ADD INSTRUCTIONS TO BE FOLLOWED IN THE EVENT YOU ARE PREGNANT (IF ANY)

I direct that my health care representative comply with the following instructions in the event that I am pregnant when this Directive becomes effective (optional):

SIGN AND DATE YOUR DOCUMENT

PRINT YOUR ADDRESS

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN BELOW

WITNESS #1

WITNESS #2

TURN TO THE NEXT PAGE TO NOTARIZE YOUR DOCUMENT INSTEAD

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decisionmaking which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____ 20 _____.

Signature _____

Address _____

City _____ State _____

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

1. Witness _____

   Address _____

   City _____ State _____

   Signature _____

   Date _____

2. Witness _____

   Address _____

   City _____ State _____

   Signature _____

   Date _____

OR

OR

A NOTARY PUBLIC OR ATTORNEY AT LAW SHOULD COMPLETE THIS SECTION

On _____, before me came _____,
(date) *(name of declarant)*

whom I know to be such person, and the declarant did then and there execute this declaration.

Sworn before me this _____day of _____, 20 _____.

_____
Signature of:

_____Notary Public
_____ Attorney at Law
(check one)

(Drafted with the assistance of Robert S. Olick, Esq., Montclair, NJ)

Courtesy of **Partnership for Caring, Inc.** 6/96
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455

INSTRUCTIONS

NEW JERSEY INSTRUCTION DIRECTIVE

INITIAL ALL STATEMENTS THAT REFLECT YOUR WISHES

If I am incapable of making an informed decision regarding my health care, I direct my loved ones and health care providers to follow my instructions as set forth below. (Initial all those that apply.)

TERMINAL CONDITION

(1) If I am diagnosed as having an incurable and irreversible illness, disease, or condition and if my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal:

_____ I direct that life-sustaining treatment which would serve only to artificially prolong my dying be withheld or ended. I also direct that I be given all medically appropriate treatment and care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

PERMANENTLY UNCONSCIOUS

(2) If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my ability to interact with other people and my surroundings:

_____ I direct that life-sustaining treatment be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate treatment and care necessary to provide for my personal hygiene and dignity.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

INCURABLE AND IRREVERSIBLE CONDITION THAT IS NOT TERMINAL

(3) If there comes a time when I am diagnosed as having an incurable and irreversible illness, disease or condition which may not be terminal, but causes me to experience severe and worsening physical or mental deterioration, and I will never regain the ability to make decisions and express my wishes:

_____ I direct that life-sustaining measures be withheld or discontinued and that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

EXPERIMENTAL AND/OR FUTILE TREATMENT

(4) If I am receiving life-sustaining treatment that is experimental and not a proven therapy, or is likely to be ineffective or futile in prolonging life:

_____ I direct that such life-sustaining treatment be withheld or withdrawn. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

SPECIFIC PROCEDURES AND/OR TREATMENT

(5) If I am in the condition(s) described above I feel especially strongly about the following forms of treatment: (initial all those that apply)

_____ I do not want cardiopulmonary resuscitation (CPR).
_____ I do not want mechanical respiration.
_____ I do not want tube feeding.
_____ I do not want antibiotics.
_____ I **do** want maximum pain relief, even if it may hasten my death.

ADD INSTRUCTIONS TO BE FOLLOWED IN THE EVENT YOU ARE PREGNANT (IF ANY)

(6) Pregnancy:

If I am pregnant at the time that I am diagnosed as having any of the conditions described above, I direct that my health care provider comply with following instructions (optional):

OBJECTION TO NEW JERSEY BRAIN DEATH DEFINITION (IF ANY)

BRAIN DEATH:

The State of New Jersey has determined that an individual may be declared legally dead when there has been an irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death). However, individuals who do not accept this definition of brain death because of their personal religious beliefs may request that it not be applied in determining their death.

Initial the following statement *only* if it applies to you:

____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared only when my heartbeat and breathing have irreversibly stopped.

ADD FURTHER INSTRUCTIONS (IF ANY)

FURTHER INSTRUCTIONS:

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decisionmaking which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

SIGN AND DATE YOUR DOCUMENT

Signed this _____ day of _____ 20 _____.

PRINT YOUR ADDRESS

Signature _____

Address _____

City _____ State _____

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN BELOW

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

WITNESS #1

1. Witness _____

Address _____

City _____ State _____

Signature _____ Date _____

WITNESS #2

2. Witness _____

Address _____

City _____ State _____

Signature _____ Date _____

OR

OR

A NOTARY PUBLIC OR ATTORNEY AT LAW SHOULD COMPLETE THIS SECTION

On _____, before me came _____,
(date) *(name of declarant)*
whom I know to be such person, and the declarant did then and there execute this declaration.

Sworn before me this _____ day of _____, 20 _____.

_____
Signature of:

_____Notary Public
_____ Attorney at Law
(check one)

(Drafted with the assistance of Robert S. Olick, Esq., Montclair, NJ)

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