New Jersey Advance Health Care Directive

On this date of ____________________ , I, ______________________________ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will
[ ] Appointment of Health Care Representative
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will

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:

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

[ ] 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.

If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one (1) 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 **(initial all those that apply)**:

[ ] 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.

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 **(initial all those that apply)**:

[ ] 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.

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 **(initial all those that apply)**:

[   ] 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.

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.

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):**

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.

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 decision-making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and my representative has 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.

Appointment of Health Care Representative

I hereby appoint ____(name), of ____ (address), 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. I direct that my health care representative comply with the following instructions and/or limitations **(optional)**:

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)**:

OPTIONAL - DESIGNATION OF ALTERNATE REPRESENTATIVE: If I revoke my representative's authority or if my representative is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate representative
______________________________ (name of individual you choose as alternate representative)
____ (address)

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 decision-making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and my representative has 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.

Designation of Primary Physician

I designate the following physician as my primary physician: ________________________ (name)
____ (address)
____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
____ (name)
____ (address)
____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes t**hat I have initialed below:**

[ ] any organs or parts **OR**

[ ] eyes [ ] bone and connective tissue [ ] skin

[ ] heart [ ] kidney(s) [ ] liver

[ ] lung(s) [ ] pancreas [ ] other __________

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation [ ] research [ ] therapy

[ ] medical education [ ] other limitations ___________________________

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will

[ ] Appointment of Health Care Representative

[ ] Designation of Primary Physician

[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature ______________________________ Date ____________________

City, County, and State of Residence ____

Notary Acknowledgment

State of ____________________

County of ____________________

On ____________________ , ______________________________ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

____

Notary Public

My commission expires ____________________

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care representative or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature ______________________________ Date ____________________

Printed Name of Witness __________________________

Witness Signature ______________________________ Date ____________________

Printed Name of Witness __________________________

Acceptance of Health Care Representative

I accept my appointment as Health Care Representative:

Signature ______________________________ Date ____________________

I accept my appointment as Alternate Health Care Representative:

Signature ______________________________ Date ____________________