New Jersey Health Care Directive and Appointment of Health Care Representative

Signing Instructions

- **This document must be signed in front of two witnesses and a notary**
- **Before signing this document fill in all of your personal information and your health care representative's name and the nature of your relationship to your representative highlighted in yellow; it is not necessary to designate a successor representative (just leave the successor information blank if there is no successor)**
- **Once you are ready to sign this document in the presence of two witnesses and a notary public, date and sign the Health Care Proxy and Living Will on page 2 in the areas highlighted in green**
- **The witnesses should read the declaration on page 2 and sign and print their names and addresses on page 2**
- **Thereafter the notary will sign on page 3, notarizing both your signature as principal and the two signatures of the two witnesses**
- **If possible, give a copy to your representative and let your agent know where the original is kept**
- **DO NOT ALTER THE WORDING OF THIS DOCUMENT**

HEALTH CARE DIRECTIVE AND
APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I, _____, of the Township (City, etc.) of _____, County of _____, and State of New Jersey, voluntarily make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care.

If at any time I should have a severe and incurable or irreversible illness, disease or condition which in the opinion of my physician is a terminal condition, or if I am permanently unconscious, and either such determination is confirmed by a second physician, I direct my attending physician to withhold or withdraw life-sustaining treatment. I specifically include in the treatment I wish to have withheld or withdrawn cardiopulmonary resuscitation, mechanical respiration and mechanically administered nutrition and hydration. I want treatment limited to measures to provide comfort and to relieve pain and authorize the administration of pain relieving drugs, even if their administration may hasten the moment of my death. I wish to live out my last days at home rather than in a hospital, nursing home, or other health care institution if that would not impose an undue burden upon my family.

I realize that it is not possible for me to anticipate the very wide variety of medical decisions which may need to be made in the future and to provide specific written directions. Accordingly, in the event I am unable to understand and appreciate the nature and consequences of health care decisions and to make an informed decision, I appoint my _____, _____, as my Health Care Representative to make all health care decisions on my behalf, including to accept or refuse medical or surgical treatment as well as to accept or withhold or withdraw life-sustaining procedures. If _____ is unavailable, unable, or unwilling to serve for any reason, then I appoint my _____, _____. I direct my Health Care Representative to carry out my basic objectives set forth above and I authorize my Health Care Representative to interpret those objectives if need be.

In addition, I authorize my Health Care Representative to direct that all life-sustaining treatment be withheld or withdrawn if I have a serious irreversible illness or condition and in my Health Care Representative's opinion the likely risks and burdens associated with the medical intervention to be withheld or withdrawn may reasonably be judged to outweigh the likely benefits to me from such intervention.

In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes. The foregoing grant of authority shall be construed broadly and shall include, without limitation, the authority to sign on my behalf all forms, waivers and releases required for my admission to or treatment at any hospital, nursing home, or other health care institution; to receive, and to consent to the disclosure of, my medical and hospital records; to employ and to discharge any of my health care providers, and, in connection therewith, to move me from one jurisdiction to any other; to give or to withhold consent to any diagnostic, medical or surgical procedure, care, or treatment, including the withholding or withdrawal of life-sustaining

procedures, medications, and artificial nutrition and hydration; to file insurance claims and to enforce the provisions of any insurance contract relating to my health care; to obligate me for the payment of all costs and expenses incurred in connection with my health care even though such costs and expenses may be uninsured; to execute any documents and to do all other things appropriate or helpful to exercising the authority given by this proxy which I would be able to do myself if I then possessed the capacity to do so. This release of authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka "HIPAA"), 42 USC 1320d and 45 CFR 160-164 and by providing this release, my Health Care Representative is acting as my personal representative pursuant to HIPAA.

I have thoroughly discussed my personal preferences and desires with my Health Care Representative and my successor Health Care Representatives. I am fully satisfied they will know best what I would wish, and I have the utmost faith and confidence in their good judgment.

I understand the full import of this directive, and I am emotionally and mentally competent to make this directive.

Dated: _____, 2020

Signature of Principal: _____

Print Name: _____

We declare that the person who signed this document did so willingly and voluntarily in our presence, is personally known to us, and is of sound mind and free of duress and undue influence. We are both 18 years of age or older, and neither of us is a designated health care representative for such person. Neither of us is a health care provider or an employee of a health care provider for such person.

Witness' Signature:_____

Print Name: _____

Address:_____

Witness' Signature:_____

Print Name: _____

Address:_____

STATE OF _____)
: ss:
COUNTY OF _____)

I CERTIFY that on _____, 2020, personally came _____ before me, who acknowledged under oath, to my satisfaction, that he/she (a) personally signed the foregoing instrument; (b) is of sound mind and free of duress and undue influence, and (c) signed the same willingly as his voluntary act and deed for the uses and purposes therein expressed.

I FURTHER CERTIFY that at the same time there appeared before me _____ and _____, whose names appear as witnesses to the foregoing signature, and said witnesses acknowledged under oath, to my satisfaction, that they saw the making of said signature, that the signing was willing and voluntary, that the person so signing was of sound mind and free of duress and undue influence, that they are both 18 years of age or older and neither is a health care provider or an employee of a health care provider for such person, and that they signed the foregoing instrument as witnesses as their voluntary act and deed.

_____
Notary Public