COMBINED ADVANCE DIRECTIVE FOR HEALTHCARE

Part 1 - PROXY DIRECTIVE (Durable Power of Attorney)

If you wish, you may use this section to designate someone to make treatment decisions if you are unable to do so or communicate those decisions. If executed below, your Instruction Directive will be in effect even if you have not designated a proxy. ***Reminder: Keep the original document in a safe place and give a copy to your primary doctor, health care representative(s) and other concerned individuals.***

I, _____ designate the following person as my health care representative to make any and all health care decisions for me acting in my best interest, in the event that I become incapable of making or communicating health care decisions.

Name _____ Relationship _____

Street _____ Home Tel: _____ Cell # : _____

City _____ State _____ Zip _____ Work Tel: _____

If the person I have named above is unable or unwilling to act as my health care representative, I hereby designate the following person(s) to do so, in the order named:

1. Name _____ Relationship _____

   Street _____ Home Tel: _____ Cell # : _____

   City _____ State _____ Zip _____ Work Tel: _____

2. Name _____ Relationship _____

   Street _____ Home Tel: _____ Cell # : _____

   City _____ State _____ Zip _____ Work Tel: _____

SPECIFIC DIRECTIONS: Please initial the statement below that best expresses your wishes:

_____ My health care representative **is authorized** to direct that artificially provided fluids and nutrition, such as by feeding tube or IV infusion, be withheld or withdrawn.

_____ My health care representative **does not have this authority**, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

PART 2 - INSTRUCTION DIRECTIVE (Living Will)

To My Family, Doctors, and All Those Concerned with My Care:

Being of sound mind, I make this statement as a directive to be followed if for any reason I become unable to make or communicate decisions regarding my health care: (Initial any that apply.)

A. _____**1.** I direct that life-sustaining procedures be withheld or withdrawn a) if I become permanently unconscious, b) if I have a terminal illness, c) if I experience extreme mental deterioration, or d) if I have another type of irreversible illness. This directive shall only apply if I am determined to have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. These medical conditions shall be determined by my attending physician and at least one additional physician. I understand that I will be kept comfortable.

OR

_____**2.** I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

If you choose A. 1., above, the life-sustaining procedures that would be withheld or withdrawn include, but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiation, dialysis, transfusion, and antibiotics. Initial the following if it applies to you (see "*Terms You Should Understand*"):

___In the circumstances described in A. 1., above, I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

B. This section asks you to think about the values that are important to you regarding treatment in cases of severe mental or physical illness. Please initial either of the following if they apply to you:

_____ **1.** I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me. The following are conditions that are **un**acceptable to me. (Initial only those that describe a way of living that you could not tolerate):

___ a) Permanently unconscious with a ventilator breathing for me.
___ b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.
___ c) On a ventilator when there is little or no chance of recovery.
___ d) Being conscious (awake), but permanently unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IVs to keep me alive.
___ e) Living with a dementia like Alzheimer's Disease so severe that I am unable to recognize those who love me.

OR

_____ **2.** I want to live as long as possible, regardless of the quality of life that I experience.

C. ___ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

Additional Instructions, Comments or Exceptions:

These directions express my legal right to request or refuse treatment. Therefore, I expect my family, doctor(s), and all those concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes.

Signed _____ Date _____

Print Name _____

This document is not considered legal unless it is signed by the person expressing their wishes in the presence of either (a) two people not named in the document as a health care representative OR (b) by a New Jersey Notary Public.

Witnesses

I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ **Date:** _____

Witness _____ **Date:** _____

STATE OF NEW JERSEY }
} ss.:
COUNTY OF BERGEN }

Be it Remembered, that on_____, before me, the subscriber, a Notary Public of New Jersey, personally appeared_____ who, I am satisfied, is the person named in and who executed the within Instrument, and thereupon he/she acknowledged that he/she signed, sealed and delivered the same as his/her act and deed, for the uses and purposes therein expressed.

_____
Notary Public