

# *The Halachic Medical Directive*

## **ADVANCE DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS**

### **FOR USE IN NEW JERSEY**

The “Halachic Medical Directive” is designed to help ensure that all medical and post-death decisions made by others on your behalf will be made in accordance with Jewish law and custom (*halacha*). The text of this Halachic Medical Directive has been approved by attorneys for use in your state as of November, 2003. While we do not expect that any future change in federal or state laws would materially affect the validity of this document, you may wish to show it to your own attorney to confirm its effectiveness in subsequent years.

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### **INSTRUCTIONS**

**(a) Please print your name on the first line of the form.**

**(b) In Section 1, print the name, address, and telephone numbers of the person you wish to designate as your *health care representative* to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own. Be sure to include all numbers (including cell phone and pager) where your representative can be reached in the event of an emergency. If the contact information for your representative changes, you should provide that updated information to everyone whom you have provided with a copy of your Halachic Medical Directive.**

**You may also insert the name, address, and telephone numbers of an *alternate representative* to make such decisions if your main representative is unable, unwilling, or unavailable to make such decisions.**

It is recommended that before appointing anyone to serve as your representative or alternate representative you should ascertain that person’s willingness to serve in such capacity. In addition, if you have made arrangements with a burial society (*Chevra Kadisha*), you may wish to advise your representatives of such arrangements.

Note: You may appoint any competent adult to serve as your health care representative (an adult is a person 18 years of age or older) *except an operator, administrator or employee of a health care institution in which you are a patient or resident, unless such person is your relative*. You may appoint your physician as your representative, however, under New Jersey law he or she cannot act as both your representative and your attending physician at the same time, so appointing your physician is not recommended.

**(c) In section 3, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your representative to follow, should any questions arise as to the requirements of *halacha*.**

**You should then print the name, address, and telephone numbers of the Orthodox Jewish institution or organization you want your representative to contact for a referral to *another***

**Orthodox Rabbi** if the rabbi you have identified is unable, unwilling or unavailable to provide the appropriate consultation and guidance.

You are, of course, free to insert the name of any Orthodox Rabbi or institution/organization you would like, but before doing so it is advisable to discuss the matter with the rabbi or institution/organization to ascertain their competency and willingness to serve in such capacity. You may list Agudath Israel of America as the organization you select; however, we are only available to be contacted on regular business days and hours.

(d) **In Section 7, sign and print your name, address, phone numbers, and the date.** If you are not physically able to do these things, New Jersey law allows another person to sign and date the form on your behalf, as long as he or she does so *at your direction, in your presence, and in the presence of two adult witnesses.*

(e) **In the DECLARATION OF WITNESSES Section, two witnesses should sign their names and insert their addresses beneath your signature.** These two witnesses must be competent adults (age 18 or older). *Neither of them should be the person you have appointed as your health care representative (or alternate representative).* They may, however, be your relatives.

**As an alternative to the witness requirement, this form can be acknowledged by you before a notary public, attorney at law, or other person authorized to administer oaths.** A Certificate of Acknowledgement of Notary Public is included in this form.

(f) It is recommended that you keep the original of this form among your valuable papers in a location that is readily accessible in the event of an emergency; and that you **distribute copies to the health care representative (and alternate representative)** you have designated in section 1, **to the rabbi and institution/organization** you have designated in section 3, as well as to **your doctors, your lawyer**, and anyone else who is likely to be contacted in times of emergency. We also recommend that you register a copy of this form with a national registry, so that it can be accessed by any health care facility via computer. Agudath Israel has made an arrangement with the New York Legal Assistance Group to register Halachic Medical Directives for our constituents with the U.S. Living Will Registry at no charge. To obtain the forms to enable you to do so, e-mail [NJdirective@agudathisrael.org](mailto:NJdirective@agudathisrael.org) or call our office (212-797-9000).

**Please note that this Directive will *not become operative until:* (i) it is transmitted to your attending physician or to the health care institution, and (ii) it is determined by your attending physician that you lack capacity to make a particular health care decision.**

(g) If at any time you wish to revoke this Advance Directive, you may do so by executing a new one; or by notifying your representative or health care provider, or other reliable witness, orally or in writing, of your intent to revoke. To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Advance Directive and destroy them.

If you do not revoke the Advance Directive, New Jersey law provides that it remains in effect indefinitely. Obviously, if any of the persons you have appointed in the Advance Directive dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new Advance Directive. Please note that the designation of your spouse as representative will be revoked upon divorce or legal separation, unless otherwise specified in the Halachic Medical Directive.

(h) It is recommended that you also complete and cut out the **Emergency Instructions Card** contained on the last page of this Halachic Medical Directive, and carry it with you in your wallet or purse.

(i) If, upon consultation with your rabbi, you would like to add to this standardized Advance Directive any additional expression of your wishes with respect to medical and/or post-mortem decisions, you may do so by attaching a “rider” to the standardized form. If you choose to do so, or if you have any other questions concerning this form, please consult an attorney.

These instructions are not part of the Halachic Medical Directive and need not be kept attached to the executed document.

**ADVANCE DIRECTIVE  
WITH RESPECT TO HEALTH CARE DECISIONS  
AND POST-MORTEM DECISIONS**

**FOR USE IN NEW JERSEY**

I, \_\_\_\_\_, hereby declare as follows:

**1. Appointment of Health Care Representative:** In recognition of the fact that there may come a time when I will become unable to make my own health care decisions because of illness, injury or other circumstances, I hereby appoint

*Representative* Name of Representative: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_

Evening: \_\_\_\_\_

Cellular phone: \_\_\_\_\_

Pager: \_\_\_\_\_

as my health care representative (“representative”) to make any and all health care decisions for me, consistent with my wishes as set forth in this directive.

If the person named above is unable, unwilling or unavailable to act as my representative, I hereby appoint

*Alternate* Name of Alternate Representative: \_\_\_\_\_

*Representative*

Address: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_

Evening: \_\_\_\_\_

Cellular phone: \_\_\_\_\_

Pager: \_\_\_\_\_

to serve in such capacity.

This appointment shall take effect in the event I become unable, because of illness, injury or other circumstances, to make my own health care decisions.

**2. Jewish Law to Govern Health Care Decisions:** I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me (whether made by my representative, a guardian appointed for me, or any other person) be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of

life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

**3. Ascertaining the Requirements of Jewish Law:** In determining the requirements of Jewish law and custom in connection with this declaration, I direct my representative to consult with the following Orthodox Rabbi and I ask my representative to follow his guidance:

***Rabbi*** Name of Rabbi: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_  
Cell: \_\_\_\_\_ Pager/beeper: \_\_\_\_\_

If such Orthodox Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, the following Orthodox Rabbi:

***Rabbi*** Name of Rabbi: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_  
Cell: \_\_\_\_\_ Pager/beeper: \_\_\_\_\_

If both of these Orthodox Rabbis are unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

***Organization*** Name of Institution/Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my representative to consult with, and I ask my representative to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my representative in good faith believes I would respect and follow.

**4. Direction to Health Care Providers:** Any health care provider shall rely upon and carry out the decisions of my representative, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my representative has not acted in good faith in accordance with my wishes as expressed in this directive. If the persons designated in section 1 above as my representative and alternate representative are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined in section 3 above in determining the requirements of Jewish law and custom.

Pending contact with the representative and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

**5. Access to Medical Records and Information; HIPAA:** My health care representative is my personal representative, as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and accordingly all of my protected health information (as such term is defined under HIPAA) and other medical records shall be made available to my health care representative upon request in the same manner as such information and records would be released and disclosed to me, and my health care representative shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records, as required under HIPAA.

**6. Post-Mortem Decisions:** It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters.

Further, subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post-mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the representative and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes. Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in paragraph 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

**7. Incontrovertible Evidence of My Wishes:** If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated in section 1 above as my representative and alternate representative are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined in section 3 above should be followed in determining the requirements of Jewish law and custom.

**8. Duration and Revocation:** It is my understanding and intention that unless I revoke this Advance Directive, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a

revocation of any prior health care proxy, directive or other similar document I may have executed prior to today's date.

***My Signature*** Signature:

\_\_\_\_\_

*(If you are not physically capable of signing, please ask another person to sign your name on your behalf.)*

Print Name:

\_\_\_\_\_

Date:

\_\_\_\_\_

Address:

\_\_\_\_\_

Telephone: Day:

Evening:

\_\_\_\_\_

### DECLARATION OF WITNESSES

I, on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, declare that the person who signed (or asked another to sign) this document is personally known to me and appears to be of sound mind and acting willingly and free from duress and undue influence. He/She signed (or asked another to sign for him/her) this document in my presence (and that person signed in my presence). I am not the person appointed as representative by this document.

***Witnesses*** Witness 1:

\_\_\_\_\_

Residing at:

\_\_\_\_\_

Witness 2:

\_\_\_\_\_

Residing at:

\_\_\_\_\_

*CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC  
(TO BE USED IN LIEU OF WITNESSES)*

STATE OF \_\_\_\_\_ )

COUNTY OF \_\_\_\_\_ ) :ss.:

On this \_\_\_\_\_ day of \_\_\_\_\_, in the year 20\_\_,

before me, \_\_\_\_\_, personally  
(insert name of notary public)

appeared \_\_\_\_\_, personally known to me  
(insert name of principal)

(or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be sound of mind and under no duress, fraud, or undue influence.

NOTARY SEAL

\_\_\_\_\_  
(signature of notary public)



### Emergency Instructions

I \_\_\_\_\_, have executed a "Halachic Medical Directive" with respect to medical and post-mortem decisions, dated \_\_\_\_\_. Pursuant to the "Halachic Medical Directive" the persons listed on the reverse of this card are to serve as my agent and alternate agent, respectively, in making health care decisions for me if I become unable to do so on my own. I desire that all such health care decisions, as well as all decisions relating to the handling and disposition of my body after I die, should be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. If there is any questions regarding Jewish law and custom, my agent (or any other person making decisions for me) should consult with and follow the guidance of the rabbi identified on the reverse of this card, or as a second choice the rabbi referred by the institution/organization identified on the reverse of this card, or as a third choice an Orthodox Rabbi whose guidance my health care decision maker in good faith believes I would respect and follow. Pending contact with my agent and/or rabbi, I desire that health care providers should undertake all essential emergency measures on my behalf; and I desire that no autopsy, organ removal, or other post mortem procedure be performed on my body without authorization from my agent and/or rabbi.

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Fold on the dotted line to create a double sided card

### EMERGENCY INSTRUCTIONS

Agent: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
Alternate Agent: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
Rabbi: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Evening: \_\_\_\_\_ Cell: \_\_\_\_\_  
Organization \_\_\_\_\_ Phone: \_\_\_\_\_