

***SAMPLE FORM ONLY—CONSULTATION WITH
LOCAL ATTORNEY REQUIRED***

The Halachic Medical Directive

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

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*). Because an updated Halachic Medical Directive has not yet been developed for your state, we are providing you with this general form to present to a local estates and trusts attorney. Different states have different laws governing these documents; this sample contains only general language that should, if possible, be included in your Halachic Living Will. **DO NOT COMPLETE THIS DOCUMENT WITHOUT CONSULTATION WITH AN ATTORNEY.**

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 *agent* 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 agent can be reached in the event of an emergency. If the contact information for your agent 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 agent* to make such decisions if your main agent is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your agent or alternate agent 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*) for the handling and disposition of your body after death, you may wish to advise your agents of such arrangements.

You need to consult with a local attorney to find out what restrictions, if any, your state laws place on who may serve as a representative.

(c) **In section 3, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your agent 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 agent 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 hours and days.

(d) **In Section 8, sign and print your name, address, phone numbers, and the date.** If you are not physically able to do these things, some state's laws 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. In most states, neither of the witnesses may be the person you have appointed as your health care agent.

All states place some restrictions on who may serve as witnesses. Consult with your attorney.

(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 agent (and alternate agent)** 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 ny.medicaldirective@agudathisrael.org or call our office (212-797-9000).

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

If you do not revoke the Proxy and Directive, under some state's laws it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Proxy and Directive dies or becomes otherwise incapable of serving in the role you have assigned, you should execute a new Proxy and Directive.

(h) It is recommended that you also complete 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 Proxy and 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.

<p>These instructions are not part of the Halachic Medical Directive and need not be kept attached to the executed document.</p>
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***PROXY AND DIRECTIVE
WITH RESPECT TO HEALTH CARE DECISIONS
AND POST-MORTEM DECISIONS***

***SAMPLE FORM ONLY—CONSULTATION WITH LOCAL ATTORNEY
REQUIRED***

I, _____, hereby declare as follows:

1. Appointment of Agent: 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

Agent	Name of Agent:	_____
	Address:	_____
	Telephone: Day:	_____
	Evening:	_____
	Cell:	_____
	Pager/beeper:	_____

as my health care agent 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 agent, I hereby appoint

Alternate Agent	Name of Alternate Agent:	_____
	Address:	_____
	Telephone: Day:	_____
	Evening:	_____
	Cell:	_____
	Pager/beeper:	_____

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.

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 agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my agent 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 agent, 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 agent 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 agent and alternate agent 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 agent 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 agent 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 agent upon request in the same manner as such information and records would be released and disclosed to me, and my agent 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. In addition, each individual nominated hereunder as my agent is a person involved in my care as set forth under HIPAA and I request that my health care providers release and disclose to such individual upon request such of my protected health information and other medical records as may be necessary for my proper care, as permitted under HIPAA, including without limitation such records and information (and the issuance and release of any written opinion requested by such individual) relating to my inability to make my own health care decisions for purposes of section 1 above.

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 agent 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 section 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 agent and alternate agent 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 proxy and 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:

Cell:

Pager/beeper:

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. 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 agent by this document.

Witnesses Witness 1:

Print Name:

Residing at:

Witness 2:

Print Name:

Residing at:

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.

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: _____