

LIVING WILL
HEALTH CARE DECLARATION
POWER OF ATTORNEY FOR HEALTH CARE
STATEMENT RELATING TO ANATOMICAL GIFTS

I, _____, residing at _____ in the Township of _____

County of _____ and state of _____, in the exercise of such legal rights

As I may have to participate in decisions relating to my physical care and treatment or to

make decisions to refuse care and treatment, hereby declare the following:

1. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

A. With respect by any Life-Sustaining Treatment, as my Health Care Declaration of "LIVING WILL", I direct the following:

REFUSAL OF TREATMENT. If I become incompetent to govern myself and manage my affairs or become unable to make or communicate decisions relating to my medical care and treatment, then this declaration shall stand as my final expression of such legal rights as I may have to refuse medical or surgical treatment and to accept the consequences of such refusal, subject only to such limitations as may be imposed upon my exercise of these rights by the Legislature or courts of the jurisdiction in which I am being cared for from time to time.

(1) If I should suffer a severe and incurable injury, disease, or illness

Certified by at least two physicians (one of whom may be my attending physician) to be Such that the application of life-sustaining procedures would serve only to postpone my Death is fairly predictable within what he or she considers to be a relatively short time as a consequence of such condition or related complications whether or not life-sustaining procedures are utilized: I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally. By way of example and not by way of limitation, such procedures may include cardiac resuscitation and mechanical respiration.

(2) I hereby authorize the administration of pain relieving drugs even if they may hasten the moment of my death.

(3) I do not wish to condition the effectiveness of this Declaration upon its conforming to any religious doctrines or beliefs to which I may be believed to subscribe unless such conditions are set forth in a writing which makes specific reference to and is attached to this Declaration. I have not made such a writing in connection with this Declaration.

(4) I have considered the possibility of limiting the effectiveness of this instrument to a fixed period of time from the date hereof and have decided that it shall remain in full force and effect for as long as I may live unless it is revoked by me.

GRANT OF DISCRETION TO AGNET. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent to consider my "Living Will", if any, the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment. If there shall be no Agent willing or able to act

hereunder to exercise the discretion conferred herein, my "Living Will" if any, shall be binding upon any health care provider and all others interested in my affairs.

A. With respect to Nutrition and Hydration provided by mechanical means or by means of a nasogastric tube or tubes into the stomach, intestines or veins, I wish to make clear that I intend to include these procedures among the "life-sustaining procedures" that may be withheld or withdrawn under the conditions given above.

B. With respect to Anatomical Gifts, I do not wish to make an Anatomical Gift.

2. DESIGNATION OF HEALTH CARE AGENT. (This instrument is to be effective as a Health Care Declaration even if no Agent is appointed). I hereby appoint, my _____, _____, of _____, in the Township of _____ County of _____ and State of _____, telephone number _____, as my Agent to make health and personal care decisions for me as authorized in this document.

3. EFFECTIVE DATE AND DURABILITY. By this document I Intend to create a durable power of attorney effective upon and only during any period of incapacity in which, in the opinion of my Agent and attending physician I am unable to make or communicate a choice regarding a particular health care decision.

4. AGENTS POWERS. I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with

me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests and consistent with my Health Care Declaration, if any. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless inconsistent with Section I or unless specifically limited below, my Agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical Care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

C. To authorize my admission to or discharge (even against medical advice) From any hospital, nursing home, hospice, residential care, assisted living or similar facility or service in this or any other jurisdiction;

D. To contract on my behalf for any health care related service or facility, without my Agent incurring personal financial liability for such contracts;

E. To hire and fire medical, social service, and other support personnel responsible for my care.

F. To authorize or refuse to authorize, in a manner not inconsistent with my Express Health Care Declaration, any medication or procedure intended to relieve pain,

Even though such use may lead to physical damage, addiction, or hasten the moment of my death.

G. To take any other action necessary to do what I authorize here, including (but not limited to) granting a waiver or release from liability required by any hospital, physician, or any other health care provided, signing any documents relating to refusals of treatment or the leaving of a facility against medical advice and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for failure to comply.

5. **SUCCESSORS.** If any agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if any Agent is my spouse) be divorced from me, I name the following (each to act alone and successively, in the order names, unless otherwise noted) as successors to my agent.

A. **Alternate Agent:** There will be no alternate Agent.

If no person named above is willing or able to serve as my Agent, but one is required by law solely in order to direct the withholding or withdrawal of life-sustaining treatment in accordance with my objectives as stated herein, I authorize my attending physician to appoint such an Agent in writing upon consultation with one or more of my relatives, friends or other persons or agencies believed to be interested in my well-being.

6. **PROTECTION OF AGENT AND THIRD PARTIES WHO RELY ON MY HEALTH CARE DECLARATION OR MY AGENT.**

No person who relies in good faith upon any representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority. The directions of said Agent shall be binding in all respects upon all

those involved in my care. My said Agent and all these acting upon his or her directions or in reliance upon my Health Care Declaration shall be entitled to indemnification from my estate in connection with all claims asserted against them unless the directions given and relied on are wholly inconsistent with my intentions as expressed above.

7. NOMINATION OF GUARDIAN. If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor), named above.

8. ADMINSTRATIVE PROVISIONS

A. I revoke any prior power of attorney for health care.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented either before or after my incapacity.

C. My Agent shall not be entitled to compensation for services performed Under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expensed incurred as a result of carrying out any provision of the power of attorney.

D. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this instrument on this _____ day of _____

PRINT NAME

WITNESS STATEMENT:

We declare that the person who signed this document, or asked another to sign

this document on his or her behalf, did so in our presence, that he or she is personally known to us, and that he or she is of sound mind and free of duress or undue influence. we are both 18 years of age or older, and neither of us is designated by this or any other document as a health care agent for such person. Neither of us is a health care provider or employee of a health care provider to such person. We each further declare that we are not related to such person by blood, marriage or adoption, and, to the best of our knowledge, are each not a creditor of such person nor entitled to any part of his or her estate under a will now existing or by operation of law.

_____ residing at _____

_____ residing at _____

STATE OF NEW JERSEY)

)SS:

COUNTY OF _____)

I certify that on _____, 2005, _____, personally came before me and this person acknowledged under oath, to my satisfaction, that this person: (a) is named in and personally signed the foregoing instrument; (b) is of sound mind and free of duress or undue influence, and (c) signed the same as his or her voluntary act and deed for the used 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 they acknowledged under oath, to my that the person so signing was of sound mind and free of duress or undue influence, and that they

signed the foregoing instrument as witnesses as their voluntary act and deed.

Notary signature and stamp_____