DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Combined Advance Directive

For

New Jersey Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Combined Advance Directive

For

New Jersey Residents

Statutory Compliant
Advance Directive for
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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Combined Advance Directive
For New Jersey Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

***Understanding Your Directive*:**

This advance directive is known as a "combined" directive because it combines a living will (or health care "instruction directive") with a power of attorney for health care (or "proxy" appointment). These two documents constitute the authorized tools for advance health care planning in New Jersey.

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) completing a Notice of Revocation, or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid.

You can **limit** your directive and the authority of anyone named in it, but it is recommended that this be done *only at the time of first completion* (although New Jersey law allows otherwise). Any scope-of-authority changes needed *after* your directive has been witnessed should be made by completing a new directive – both to limit future confusion, and to prevent questions about the validity of subsequent changes.

If you are **unable to write**, you may tell your required witnesses what you want to have excluded, limited, or added to this directive. They should make the changes you have requested, secure a third person to sign in your behalf and at your direction, and then witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Finally, some questions in this directive may be difficult to answer. However, these challenging questions may well be decided by someone else if they are not decided by you, now.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

If there is anything in this Directive you do not understand, you should read the Guidebook, ask your physician or a health care professional, or call an attorney for help.

SECTION I:

New Jersey Living Will

INSTRUCTION DIRECTIVE

(NJ General Laws, Title 26:§26:2H-53 - §26:2H-78)

1. INTRODUCTION. *New Jersey advance directive statutes allow for life-sustaining treatment to be provided in all medically appropriate circumstances, and to be withheld or withdrawn in the following situations: "1) When the life-sustaining treatment is experimental and not a proven therapy,* ***or*** *is likely to be ineffective or futile in prolonging life,* ***or*** *is likely to merely prolong an imminent dying process; 2) When the patient is permanently unconscious...; 3) When the patient is in a terminal condition...; or 4) In the event none of the above circumstances applies, when the patient has a serious irreversible illness or condition, and the likely risks and burdens associated with the medical intervention to be withheld or withdrawn may reasonably be judged to outweigh the likely benefits ...from such intervention,* ***or*** *imposition of the medical intervention on an unwilling patient would be inhumane." (§26:2H-67, emphases added).*

Intent to Complete:

2. I have chosen *not* to complete an Instruction Directive at this time, but I *do* want to complete a Durable Power of Attorney for Health Care and Proxy Directive (*sign below, and skip forward to page 6*):

   Signature: _____ Date: _____

   OR:

3. I, _____, being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided in Section I of this advance directive document are to be recognized as my Instruction Directive and living will, and to serve as evidence of my health care treatment wishes. These instructions should be used to guide to any health care professional, agent, proxy, surrogate, representative, family member, guardian, conservator, or other persons or entities providing, overseeing, or making medical decisions regarding my care in the

event I am unable to make my wishes otherwise known.

4. *Specific Health Care Directives*: I have specific wishes regarding the delivery of medical care in certain health care conditions. Therefore, in the following conditions, I wish to direct my medical treatment as follows:

_____ If I am ever **imminently dying**, and life-sustaining treatment is serving only to **delay the moment of my death**:

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

_____ If I am ever diagnosed with a **terminal** illness, disease, or injury, and generally given six months or less to live:

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

_____ If I am ever diagnosed as being **permanently unconscious** (in a coma, or a persistent vegetative condition):

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

_____ If I am ever diagnosed with an irreversible illness or condition which may not be terminal, but which **imposes serious mental, physical or other burdens**, such that a reasonable person could conclude the burdens outweigh the likely benefits:

- I do [_____], or I do not [_____] want life-sustaining medical treatment used in any attempt to try and prolong my life.

5. *Clarifying "life-sustaining medical treatment*." In the situations described above, I wish to leave the following directions about the treatments and procedures which may be used, withdrawn, or withheld:

- I do [_____], or I do not [_____] want **cardiac resuscitation (CPR)** used in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want **breathing machines** used to replace or support my natural breathing (i.e., "respirators, "ventilators" or other such devices) in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want food and water to be given me through **tubes, IV lines, or other medical devices** in any attempt to try and prolong my life.

- I do [_____], or I do not [_____] want **antibiotics** used in any attempt to try and prolong my life.

6. *Comfort Care and Pain Relief*. In the specific medical situations I have outlined above, I provide the following directions about comfort care and pain relief:

   - I do [_____], or I do not [_____] want maximum pain relief, if it may ***unintentionally*** **hasten my death**.

   - I do [_____], or I do not [_____] want maximum pain relief, if it may result in ***temporary*** **addiction**, if I should survive an extended hospital stay.

7. If I am pregnant and decisions must be made about life-sustaining treatment, I direct as follows (*optional*): (*initial only one*)

   _____ Not applicable (never, or no longer possible).

   _____ Any choices I have made in this document which may compromise the health of the baby (if it appears the baby can develop to the point of survival following birth) shall be deferred until after the birth has occurred. It is my intent, however, that any and all choices or directions which do *not* so effect the health of the baby will remain in full effect.

   _____ My directive representative (if appointed) or involved others should make choices based upon my immediate circumstances.

8. *Other Directions*. I wish to provide the following additional directions: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

9. ***Signature of Principal and Witnesses***:

These directions express my legal right to accept or refuse treatment under the laws of New Jersey. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this Document, and understand its full purpose, effect, and import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*Sign in the presence of two qualified witnesses; see below*)

10. Signed: _____

Date: _____

Address: _____

11. Signed: _____

Date: _____

Address: _____

Statement of Witnesses

12. I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has had opportunity to read this document, and has signed or acknowledged his/her signature or mark in my presence. This document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or of the current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, nor am I involved in directly physically caring for the individual, and to the best of my knowledge I am not entitled to any part of the individual's estate upon his or her death under a will now existing nor by any other operation of law.

13. Witness: _____

Printed Name:_____

Address: _____

14. Witness: _____

Printed Name:_____

Address: _____

SECTION II:
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Proxy Directive and Designation of Health Care Representative

(Pursuant to NJ General Laws: Title 26:§26:2H-53 to §26:2H-78 and Title §46:46:2B-8.1 to §46:46:2B-19)

15. INTRODUCTION. *This section lets you name a person to make health care decisions for you if you cannot make them for yourself. The person must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice*.

16. ***Be it known that I***:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ Intend by this document to create a durable power of attorney for health care (proxy directive). This power of attorney for health care shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that execution of this document is voluntary and without duress. Creation of this power of attorney is for the designation of a health care representative or proxy (hereafter known as my "Agent" or "Attorney-in-fact") to act in my place to make medical decisions for me if I become unable to make them for myself. It also grants my agent the authority to make other legal and personal care decisions as outlined in this document. This designation is effective when, in the opinion of at least one licensed medical doctor who has personally examined me, I am no longer able make personal medical treatment decisions for myself. By creating this document I revoke any prior power of attorney for health care or health care proxy appointment.

17. I understand that I am <u>not</u> required to choose a health care agent to have my Instructions and wishes in "Section I" recognized, but that I am advised to do so to ensure that my wishes are fully represented and followed. Therefore: (*initial only <u>one</u>*)

_____ I do <u>not</u> want to choose a health care agent at this time (*or I have no one appropriate to the task*). However, I direct that Section I of this document, my Instruction Directive, be recognized as a declaration of my wishes within this Advance Health Care Directive (*proceed now to page 25 and sign*);

***OR*,**

_____ I <u>do</u> wish to appoint a health care agent. I recognize that, in accordance with New Jersey law, this person may ***<u>not</u>*** be an operator, administrator or employee of a health care institution in which I reside, *unless* this agent is also related to me by blood, marriage, or adoption. A physician, however, can serve as my health care

agent only if he or she is not serving as my attending physician *and* health care agent at the same time.

The person I have chosen to act as my health care agent and to whom I give **full** authority to make all medical and other health care decisions for me at any time during which I am unable to make them for myself, is:

18. **Name of Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

19. If for any reason I revoke the authority of my agent, or this individual is unavailable, unable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate agents:

20. **Name of Alternate #1:**_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

21. **Name of Alternate #2:** _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

22. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal and health care decisions. In making decisions in my behalf *if my wishes are not clear*, I direct my agent and successors to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life.

23. **Additional statement of Desires, Special Provisions, and Limitations**.
Noted below are any added limitations or other provisions which my health care agent must follow in acting in his or her representative capacity:

24. *Additional Clarification of Agent Authority*: If I have designated an agent to represent me in making medical decisions, I want others to know that his or her authority specifically includes the following, whether allowed by specific federal law, statutory law, case law, or by extension of common law:

(*initial to authorize; cross out or leave blank if not authorized*)

A. _____ My agent is specifically authorized to make decisions about whether artificial feeding (tube feeding) and hydration (IV lines placed in my veins to give me nutrition or water) can be used, limited (e.g., for delivery of medications only), withheld or withdrawn.

B. _____My agent is specifically authorized to make decisions about whether comfort medications (pain medications, etc) – *including those which might unintentionally hasten my death or produce temporary addiction* – can be given, withheld or withdrawn.

25. *Instruction Directive Incorporation (if completed) and Agent directives (if appointed)*: I intend for my agent to follow, incorporate and enforce as medical and attorney-in-fact directives, any and all wishes as outlined in the Living Will Instruction contained in Section I this advance directive document.

26. *Other Wishes*: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Statement and Signature of Principal/grantor:

27. This document is governed by New Jersey law, although I request that it be honored in any state in which I may be found.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*<u>Must</u> be signed <u>in the presence</u> of two qualified witnesses; notarization is not required, but <u>is</u> recommended as witnesses may become unavailable in the future*)

28. Signed:_____ Date: _____

At: (City) _____ (State) _____

Qualified Witnesses

29. This Advance Directive for Health Care may not be upheld unless it is: (1) signed by two adult witnesses who are personally present when you sign or to whom you personally acknowledge your signature. Notarization is not required, but Lifecare staff recommend notarization as well, as witnesses may become unavailable in the future. Your witnesses must qualify to sign the following statement:

Statement of Witnesses:

30. I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has had opportunity to read this document, and has affixed (or caused to be affixed) his/her signature or mark in our mutual presence. It appears that this document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. I am not the agent or an alternate or successor named in this document. Further, I am not the attending physician or other health care provider, nor an employee of the physician or other health care provider, nor that of a current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for he principal, and to the best of my knowledge I have no claim against nor am I entitled to any part of the principal's estate upon his or her death under a deed, will or codicil now existing, nor by any other operation of law.

3. 1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

32. 2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

33. State of New Jersey,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the health care representative (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

34. _____ **Notary Seal:**

Signature of Notary Public

_____

Date Commission Expires

PHOTOCOPIES AND FACSIMILES:

35. A photocopy (photostatic copy) or electronic facsimile ("fax") of this document shall be deemed as valid as the original. I understand I should keep the original copy, and give copies of the original to 1) my health care representative and alternates, 2) my physician(s), 3) members of my family and others who might be called in the event of a medical emergency, and 4) any hospital or other health care facility where I receive treatment. My health care representative(s) and my family or friends should be directed to give a copy of this directive to my health care provider(s) or physician(s) upon request.

36. INDIVIDUALS AND INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

Name: ______________________________
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Fax: (_____) ______ - ______________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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