

**PRINT THE
NAME, ADDRESS
AND
TELEPHONE
NUMBER OF
YOUR SECOND
ALTERNATE
HEALTH CARE
REPRESENTA-
TIVE**

2. Name _____

Address _____

City _____ State _____

Telephone _____

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

I direct that my health care representative comply with the following instructions and/or limitations (optional):

**ADD
INSTRUCTIONS
TO BE
FOLLOWED IN
THE EVENT YOU
ARE PREGNANT
(IF ANY)**

I direct that my health care representative comply with the following instructions in the event that I am pregnant when this Directive becomes effective (optional):

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decisionmaking which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this _____ day of _____ 20 _____.

Signature _____

Address _____

City _____ State _____

**SIGN AND DATE
YOUR
DOCUMENT**

**PRINT YOUR
ADDRESS**

**WITNESSING
PROCEDURE**

**YOUR
WITNESSES
MUST SIGN
BELOW**

WITNESS #1

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

1. Witness _____

Address _____

City _____ State _____

Signature _____

Date _____

2. Witness _____

Address _____

City _____ State _____

Signature _____

Date _____

**WITNESS #2
TURN TO THE
NEXT PAGE TO
NOTARIZE YOUR
DOCUMENT
INSTEAD**

OR

OR

**A NOTARY
PUBLIC OR
ATTORNEY AT
LAW SHOULD
COMPLETE THIS
SECTION**

On _____, before me came _____,
(date) *(name of declarant)*

whom I know to be such person, and the declarant did then and there
execute this declaration.

Sworn before me this _____ day of _____, 20 _____.

Signature of:

____ Notary Public

____ Attorney at Law

(check one)

(Drafted with the assistance of Robert S. Olick, Esq., Montclair, NJ)

INSTRUCTIONS

NEW JERSEY INSTRUCTION DIRECTIVE

**INITIAL ALL
STATEMENTS
THAT REFLECT
YOUR WISHES**

If I am incapable of making an informed decision regarding my health care, I direct my loved ones and health care providers to follow my instructions as set forth below. (Initial all those that apply.)

**TERMINAL
CONDITION**

(1) If I am diagnosed as having an incurable and irreversible illness, disease, or condition and if my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal:

____ I direct that life-sustaining treatment which would serve only to artificially prolong my dying be withheld or ended. I also direct that I be given all medically appropriate treatment and care necessary to make me comfortable and to relieve pain.

____ I direct that life-sustaining treatment be continued, if medically appropriate.

**PERMANENTLY
UNCONSCIOUS**

(2) If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my ability to interact with other people and my surroundings:

____ I direct that life-sustaining treatment be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate treatment and care necessary to provide for my personal hygiene and dignity.

____ I direct that life-sustaining treatment be continued, if medically appropriate.

**INCURABLE
AND
IRREVERSIBLE
CONDITION
THAT IS NOT
TERMINAL**

(3) If there comes a time when I am diagnosed as having an incurable and irreversible illness, disease or condition which may not be terminal, but causes me to experience severe and worsening physical or mental deterioration, and I will never regain the ability to make decisions and express my wishes:

_____ I direct that life-sustaining measures be withheld or discontinued and that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

**EXPERIMENTAL
AND/OR FUTILE
TREATMENT**

(4) If I am receiving life-sustaining treatment that is experimental and not a proven therapy, or is likely to be ineffective or futile in prolonging life:

_____ I direct that such life-sustaining treatment be withheld or withdrawn. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

_____ I direct that life-sustaining treatment be continued, if medically appropriate.

**SPECIFIC
PROCEDURES
AND/OR
TREATMENT**

(5) If I am in the condition(s) described above I feel especially strongly about the following forms of treatment: (initial all those that apply)

_____ I do not want cardiopulmonary resuscitation (CPR).

_____ I do not want mechanical respiration.

_____ I do not want tube feeding.

_____ I do not want antibiotics.

_____ I **do** want maximum pain relief, even if it may hasten my death.

**ADD
INSTRUCTIONS
TO BE
FOLLOWED IN
THE EVENT YOU
ARE PREGNANT
(IF ANY)**

(6) Pregnancy:

If I am pregnant at the time that I am diagnosed as having any of the conditions described above, I direct that my health care provider comply with following instructions (optional):

**OBJECTION TO
NEW JERSEY
BRAIN DEATH
DEFINITION
(IF ANY)**

BRAIN DEATH:

The State of New Jersey has determined that an individual may be declared legally dead when there has been an irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death). However, individuals who do not accept this definition of brain death because of their personal religious beliefs may request that it not be applied in determining their death.

Initial the following statement *only* if it applies to you:

_____ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared only when my heartbeat and breathing have irreversibly stopped.

**ADD FURTHER
INSTRUCTIONS
(IF ANY)**

FURTHER INSTRUCTIONS:

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decisionmaking which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

**SIGN AND DATE
YOUR
DOCUMENT**

Signed this _____ day of _____ 20 _____.

Signature _____

Address _____

City _____ State _____

**PRINT YOUR
ADDRESS**

**WITNESSING
PROCEDURE**

**YOUR
WITNESSES
MUST SIGN
BELOW**

WITNESS #1

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

1. Witness _____
Address _____
City _____ State _____
Signature _____ Date _____

WITNESS #2

2. Witness _____
Address _____
City _____ State _____
Signature _____ Date _____

OR

OR

**A NOTARY
PUBLIC OR
ATTORNEY AT
LAW SHOULD
COMPLETE THIS
SECTION**

On _____, before me came _____,
(date) *(name of declarant)*
whom I know to be such person, and the declarant did then and there
execute this declaration.

Sworn before me this _____ day of _____, 20 _____.

Signature of:

____ Notary Public

____ Attorney at Law

(check one)

(Drafted with the assistance of Robert S. Olick, Esq., Montclair, NJ)