	New Jersey Appointment of a Health Care Representative		
PRINT YOUR NAME	I,, <i>(name)</i>		
PRINT THE NAME, ADDRESS AND	hereby appoint:		
HOME AND WORK	(address of health care representative)		
TELEPHONE NUMBERS OF YOUR HEALTH CARE REP.	Image: characterized constraintsImage: characterized constraints(home phone number)(work phone number)to be my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life- sustaining treatment. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, or if a situation arises that I did not anticipate, my health care representative is authorized to make decisions in my best interests.If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the following order of priority:		
PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR FIRST ALTERNATE HEALTH CARE REPRESENTA- TIVE	1. Name		
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	New Jersey Appointment of a Health Care Representative — Page 2 of 4
P RINT THE	2. Name
NAME, ADRESS AND TELEPHONE NUMBER OF YOUR SECOND	Address
	City State
	Telephone
ALTERNATE HEALTH CARE	
REPRESENTA-	
TIVE	
ADD PERSONAL INSTRUCTIONS (IF ANY)	I direct that my health care representative comply with the following instructions and/or limitations (optional):
ADD INSTRUCTIONS	I direct that my health care representative comply with the following instructions in the event that I am pregnant when this Directive becomes
TO BE	effective (optional):
FOLLOWED IN THE EVENT YOU	
ARE PREGNANT (IF ANY)	
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	NEW JERSEY APPOINMENT OF A HEALTH CARE REPRESENTATIVE — PAGE 3 OF 4		
	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	Signed this day of 20		
YOUR	Signature		
DOCUMENT	Address		
PRINT YOUR ADDRESS	City State		
ADDREOG			
WITNESSING PROCEDURE YOUR WITNESSES MUST SIGN BELOW	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.		
WITNESS #1	1. Witness		
	Address		
	City State		
	Signature		
	Date		
WITNESS #2	2. Witness		
TURN TO THE NEXT PAGE TO	Address		
NOTARIZE YOUR	City State		
DOCUMENT INSTEAD	Signature		
© 2000	Date		
PARTNERSHIP FOR CARING, INC.			

	New Jersey Appointment of a Health Care Representative — Page 4 of 4		
OR	OR		
A NOTARY PUBLIC OR ATTORNEY AT LAW SHOULD COMPLETE THIS SECTION	On, before me came, <i>(name of declarant)</i> , 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 <i>(check one)</i>		
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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.

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	New Jersey Instruction Directive — Page 2 of 4
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	(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)
AND/OR TREATMENT	I do not want cardiopulmonary resuscitation (CPR). I do not want mechanical respiration. I do not want tube feeding. I do not want antibiotics.
ADD INSTRUCTIONS	I do not want antibioties. I do want maximum pain relief, even if it may hasten my death.
TO BE FOLLOWED IN	(6) Pregnancy:
THE EVENT YOU ARE PREGNANT (IF ANY)	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):
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	New Jersi	EY INSTRUCTION DIRECT	IVE — PAGE 3 OF 4
OBJECTION TO NEW JERSEY BRAIN DEATH DEFINITION (IF ANY)	declared legally deac functions of the entr whole brain death). F	d when there has been t ire brain, including the lowever, individuals wh se of their personal relig	l that an individual may be an irreversible cessation of all e brain stem (also known as ho do not accept this definition tious beliefs may request that it
	Initial the following s	tatement <i>only</i> if it appli	ies to you:
	standard would	to be declared only whe	ne whole brain death eligious beliefs. I therefore n my heartbeat and breathing
ADD FURTHER INSTRUCTIONS (IF ANY)	FURTHER INSTRUCT	<u>'IONS:</u>	
	responsible for my hear of decisionmaking whe the terms of this desi	alth care of my wishes a lich this responsibility a gnation with my health	rm those who may become and intend to ease the burdens may impose. I have discussed care representative(s) and my
	acting on my behalf	in accordance with this se and effect of this do	o accept the responsibility for is directive and my wishes. I cument and sign it knowingly,
SIGN AND DATE	Signed this	day of	20
YOUR DOCUMENT	Signature		
PRINT YOUR	Address		
ADDRESS	City		_ State
© 2000 Partnership for Caring, Inc.			

	New Jersey Instruction Directive — Page 4 of 4				
WITNESSING PROCEDURE YOUR WITNESSES MUST SIGN BELOW	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.				
WITNESS #1	1. Witness				
	Address				
	City State				
	Signature Date				
WITNESS #2	2. Witness				
	Address				
	City State				
	Signature Date				
OR	OR				
A NOTARY	On, before me came,				
PUBLIC OR ATTORNEY AT LAW SHOULD	<i>(date) (name of declarant)</i> whom I know to be such person, and the declarant did then and there execute this declaration.				
COMPLETE THIS SECTION	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)				
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