

**Medical Power of Attorney**

**Instruction Directive**

The decision to fill out an advance directive is your choice. Your medical care does not depend on whether or not you complete an advance directive. Please consider your advance directive choices carefully. It is important that you fully understand its meaning and what treatment you will receive as a result of it. Please note that this form goes into effect only if you are unable to make your own healthcare decisions.

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and they will turn to someone who I trust and who knows my values and health care wishes. By writing this durable power of attorney for health care, I appoint a health care representative with the legal authority to make health care decisions on my behalf after consulting with my physician. I direct that this document become part of my permanent medical record.

**HEALTH CARE REPRESENTATIVE (Medical Power of Attorney)**

I \_\_\_\_\_ hereby designate  
\_\_\_\_\_ as my health care representative.

Relationship \_\_\_\_\_

Residing at \_\_\_\_\_

Telephone Number: \_\_\_\_\_

This document allows my health care representative to make any and all health care decisions for me, including the decision to accept or refuse treatment, service or procedure used to diagnose or treat my physical or mental condition, the decision to withhold or withdraw life-sustaining medical treatment, to include the initiation of a "Do Not Resuscitate" request. I direct that my health care representative make decisions on my behalf in accordance with my wishes as stated in this document or as otherwise known to him/her. In the event that my wishes are not clear, my health care

representative is authorized to make decisions that he/she feels are in my best interest based upon the medical information that is provide by the health care team.

This durable power of attorney for health care shall take effect in the event that I become unable to make my own health care decisions as determined by the physician who has primary responsibility for my care.

### **ALTERNATE REPRESENTATIVES**

If the person that I have designated 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:

Name \_\_\_\_\_

Address & Telephone: \_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_

Address & Telephone: \_\_\_\_\_

\_\_\_\_\_

### **INSTRUCTIVE DIRECTIVE**

I, \_\_\_\_\_ being or sound mind make this statement as a directive to be followed if for any reason I become unable to participate in the decision-making regarding my health care.

A) \_\_\_\_\_ If my condition becomes so serious that there is no reasonable chance of recovery or regaining a meaningful quality of life, (such as – (1) I have an incurable and irreversible condition that will result in my death within a relatively short time; (2) I become unconscious and there is no reasonable chance of my regaining consciousness; or (3) the likely risks and burdens of treatment would outweigh the expected benefits. Life-Prolonging measures should not be started or if they have been started, they should be stopped. Those life-prolonging procedures or treatments include: mechanical ventilation/respirator, CPR (chest compressions, electric shock, rescue breathing, epinephrine or inotropic agents), artificially administered fluids and/or nutrition, chemotherapy, surgery, radiation, antiarrhythmic or vasoactive medications and dialysis.

B)\_\_\_\_\_I direct that all measures and/or treatments be provided to prolong my life regardless of my condition.

C)\_\_\_\_\_Additional comments or instruction:\_\_\_\_\_

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### **ORGAN DONATION**

\_\_\_\_\_Upon my death I am willing to donate any part(s) of my body that may benefit others.

### **SIGNATURE**

By writing this durable power of attorney for health care, I am informing those entrusted with my care of my wishes and intent to ease the burden of decision-making which this responsibility may impose. I have discussed the terms of this designation with my health care representatives and he/she is willing to accept this responsibility and carry out my wishes. I understand the purpose and effect of this document and sign it voluntarily after careful consideration.

SIGNED ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 20

SIGNATURE:\_\_\_\_\_

PRINT NAME\_\_\_\_\_

WITNESSES: I declare that the person who signed this document did so in my presence; that he/she is known to me; that he/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 this person's health care representative. You must have either two witnesses, OR a notary or an attorney-at-law in the State of New Jersey; sign in order to validate this document.

WITNESS: (Signature, printed name & date)

(1)\_\_\_\_\_

(2)\_\_\_\_\_

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