New Jersey Advance Directive for Health Care
(Living Will)

** I, _____ (print your name), being of a sound mind and a competent adult knowing my right regarding medical care and treatment, do hereby execute this legally binding document expressing my wishes and directions to my family and health care providers of the treatment and care that I desire in the event that I am prevented by either physical or mental incapacity from making future medical decisions.

A - Terminal Condition

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

1. _____ 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.

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

B – Permanently Unconscious

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:

1. _____ 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.

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

C – Incurable and Irreversible Conditions that are not Terminal

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 physical or mental deterioration and I will never regain the ability to make decision and express my wishes:

1. _____ I direct that such life-sustaining treatment be withheld or withdrawn.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.

2. _____ I direct that life-sustaining treatment be continued.

D – Experimental and/or Futile Treatment

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:

1. _____ 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.

E – Brain Death

The State of New Jersey has enacted legislation that has determined that an individual may be declared legally brain dead when there has been an irreversible cessation of all the functions of the brain, including the brain stem (this is also known as whole brain death). However, should this definition interfere with personal religious beliefs of individuals, they may request that it not be applied.

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

F – Specific Procedures and/or Treatments

If I am in any of the conditions described above, I feel especially strong about the following forms of treatment:

I do want_____	I do not want_____ cardiopulmonary resuscitation
I do want_____	I do not want_____ mechanical respiration
I do want_____	I do not want_____ tube feeding
I do want_____	I do not want_____ antibiotics
I do want_____	I do not want_____ maximum pain relief
I do want_____	I do not want_____ kidney dialysis

I do want_____ I do not want_____ surgery (such as amputation)
I do want_____ I do not want_____ blood transfusion
I do want_____ I do not want_____ to die at home

G – Organ Donation

I do want_____ I do not want_____ to donate my organs

SPECIFIC INSTRUCTIONS

(Please write in your own hand your end of life instructions, directions and treatment preferences and sign your signature.)

HIPAA PROVISION IN MEDICAL DIRECTIVES

The Medical Decision Attorney-in-Fact named in this document is hereby designated as my "Personal Representative" as DEFINED BY 45 CFR 164.502 (g), commonly known as the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 (HIPAA). This individual is to have the same access to my health care and treatment information as I would have if I were able to act for myself. My Medical Decision Attorney-in-Fact and Personal Representative named herein is also authorized to take any and all legal steps necessary to ensure his or her access to information and such action shall include resorting to legal process, if necessary, to enforce my rights under the law and shall attempt to recover attorneys fees as authorized by New Jersey law, in enforcing my rights. _____

Signature