

**PROXY DIRECTIVE--(Durable Power of Attorney for Health Care)
Designation of Health Care Representative**

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 decision. In these circumstances, those caring for me will need direction and they will turn to someone 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 and to consult with my physician and others. I direct that this document become part of my permanent medical records.

A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I, _____, hereby designate _____,
of _____

(home address and telephone number of health care representative)

as 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 measures. I direct my 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, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

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

B) ALTERNATE REPRESENTATIVES: 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 order of priority stated:

- | | |
|------------------------|------------------------|
| 1. name _____ | 2. name _____ |
| address _____ | address _____ |
| city _____ state _____ | city _____ state _____ |
| telephone _____ | telephone _____ |

C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

_____ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care

(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

Four horizontal lines for additional instructions or statements.

D) COPIES: The original or a copy of this document has been given to my health care representative and to the following:

- 1. name address city state telephone
2. name address city state telephone

E) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burdens of decision making which this responsibility may impose.

Signed this day of, 20 signature address city state

F) WITNESSES: 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.

- 1. witness address city state signature date
2. witness address city state signature date