

NEW JERSEY
Advance Directive
Planning for Important Health care Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Advance Directive

This packet contains legal documents which protect your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself. It becomes effective once: (1) it is transmitted to your attending physician or health care institution; and (2) your attending physician and one other doctor confirms in writing that you are unable to make decisions regarding your health care. Such determination of your decision making incapacity shall be made part of your medical record and notice shall be given to your health care representative or proxy.

1. The **New Jersey Appointment of a Health care Representative** lets you name someone to make decisions about your medical care, including decisions about life-sustaining treatment, if you can no longer make health care decisions for yourself.
2. The **New Jersey Instruction Directive**. It lets you provide instruction and direction regarding your wishes about medical care in the event that you develop a terminal condition or are permanently unconscious and can no longer make your own medical decisions. The Living Will becomes effective when, in addition to the conditions for effectiveness of the Advance Directive listed in the paragraph above, your doctor and one other physician document in your medical record that you are in a terminal condition or permanently unconscious.

You may use either one or both of these documents.

Note: This document will be legally binding only if the person completing the document is a competent adult (18 years of age or older.)

Instructions Completing Your Advance Directive for Health care

How do I make my *Advance Directive for Health care* legal?

The law requires that you sign your document, or direct another to sign it;

1. in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative;

OR

2. before a notary public, an attorney at law, or another person authorized to administer oaths

Your advance directive becomes effective once: (1) it is transmitted to your attending physician or health care institution; and (2) your attending physician and one other doctor confirms in writing that you are unable to make decisions regarding your health care. Such determination of your decision making incapacity shall be made part of your medical record and notice shall be given to your health care representative.

Can I add personal instructions to my Living Will?

Yes. You can add personal instructions to your living will. For example, if there are any specific forms of treatment that you wish to refuse that are not already listed in the document, you may list them here. You may also direct your health care representative to consult with specified individuals such as family members in the course of making decisions. Your health care representative is required to act in good faith and within the bounds of authority granted by the advance directive.

One of the strongest reasons for naming a representative is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. Talk with your representative about your future medical care and describe what you consider to be an acceptable "quality of life."

Instructions Completing Your Advance Directive for Health care (continued)

Whom should I appoint as my representative?

A representative is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. (A representative may also be called an “agent” or “proxy”.) You can appoint a second person as your alternate representative. The alternate will step in if the first person you name as your representative is unable, unwilling, or unavailable to act for you. The person you name as your representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You **can** appoint a family member, including, but not limited to your spouse or domestic partner or a close friend whom you trust to make serious decisions.

If you designate your spouse as your representative, his or her authority is automatically revoked upon divorce or legal separation, unless otherwise specified in the Advance Directive. If you designate your domestic partner, his or her authority is automatically revoked upon termination of your domestic partnership, unless otherwise specified in the Advance Directive.

You **cannot** appoint an operator, administrator or employee of your treating health care institution, unless he or she is related to you by blood, marriage, domestic partnership, or adoption. However, you can appoint a physician so long as he or she is not serving as your attending physician at the same time.

Before your representative can make decisions on your behalf, your doctor or treating health care institution must receive a copy of the Appointment of Health care Representative, and your attending physician and one other doctor must confirm that you are unable to make health care decisions.

Completing Your Directive for Health care (continued)

What if I change my mind?

You may modify at any time your entire Advance Directive, your Living Will, or your Health care Representative by complying with the same requirements for execution of any of those documents.

You may revoke your entire Advance Directive, your Living Will, or your Health care Representative at any time by:

- Announcing your revocation either orally or in writing to your health care representative, your doctor or other health care provider, or a reliable witness;
- Any other act which demonstrates your intent to revoke the document(s); or
- Executing a subsequent Advance Directive, Living Will, or Health care Representative document.

If you designate your spouse as your representative, his or her authority is automatically revoked upon divorce or legal separation, unless otherwise specified in the Advance Directive. If you designate your domestic partner, his or her authority is automatically revoked upon termination of your domestic partnership, unless otherwise specified in the Advance Directive.

INSTRUCTIONS

NEW JERSEY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE – PAGE 1 OF 5

PRINT YOUR NAME

I, _____, hereby appoint:
(name)

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR HEALTH CARE REPRESENTATIVE

(name of health care representative)

(address of health care representative)

_____ (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 REPRESENTATIVE

1. Name _____

Address _____

City _____ State _____

Telephone _____

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**NEW JERSEY APPOINTMENT OF A HEALTH CARE
REPRESENTATIVE- PAGE 2 OF 5**

PRINT THE NAME,
ADDRESS AND
TELEPHONE
NUMBER OF
YOUR SECOND
ALTERNATE
HEALTH CARE
REPRESENTATIVE

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):

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NEW JERSEY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE - PAGE 3 OF 5

IF YOU HAVE NOT MADE A GIFT OR EXPLICITLY REFUSED TO MAKE A GIFT OF YOUR ORGANS ELSEWHERE, YOUR HEALTH CARE REPRESENTATIVE WILL HAVE AUTHORITY TO MAKE SUCH A GIFT, IN ACCORDANCE WITH ANY INSTRUCTIONS YOU PROVIDE.

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES.

I authorize my agent to make this anatomical gift if medically acceptable to take effect upon my death. The words and marks below indicate my desires.

Upon my death, I wish to donate:

_____ My body for anatomical study if needed.

_____ Any needed organs, tissues, or eyes.

_____ Only the following organs, tissues, or eyes:

I authorize the use of my organs, tissues, or eyes:

_____ For transplantation

_____ For therapy

_____ For research

_____ For medical education

_____ For any purpose authorized by law.

This authority granted to my patient advocate to make an anatomical gift is limited as follows (here list limitations or special wishes, if any):

**NEW JERSEY APPOINTMENT OF A HEALTH CARE
REPRESENTATIVE - PAGE 4 OF 5**

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 decision making 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
PRINT YOUR
ADDRESS

Signed this _____ day of _____ 20 _____.

Signature _____

Address _____

City _____ State _____

WITNESSING
PROCEDURE

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 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.

YOUR WITNESSES
MUST SIGN BELOW

WITNESS #1

1. Witness _____

Address _____

City _____ State _____

WITNESS #2

Signature & Date _____

2. Witness _____

Address _____

City _____ State _____

Signature & Date _____

TURN TO THE
NEXT PAGE TO
NOTARIZE YOUR
DOCUMENT

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NEW JERSEY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE - PAGE 5 OF 5

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)

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INSTRUCTIONS

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.)

For purposes of the provisions below, life-sustaining treatment means: the use of any medical device or procedure, artificially provided fluids, nutrition, drugs, surgery or therapy that use artificial means to sustain a vital bodily function to increase life span, which would serve only to artificially prolong my dying,

- (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 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.

- (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.

INITIAL ALL
STATEMENTS
THAT REFLECT
YOUR WISHES

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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 either (1) experimental and not a proven therapy, or (2) 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):

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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.

ORGAN DONATION
(OPTIONAL)

ORGAN DONATION (OPTIONAL)

Under New Jersey law, you may make a gift of all or part of your body. In the space below you may make a gift yourself or state that you do not want to make a gift.

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent or your family will have the authority to make a gift of all or part of your body under New Jersey law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or

Upon my death, I wish to donate:

- _____ My body for anatomical study if needed.
- _____ Any needed organs, tissues, or eyes.
- _____ Only the following organs, tissues, or eyes:

I authorize the use of my organs, tissues, or eyes:

- _____ For transplantation
- _____ For therapy
- _____ For research
- _____ For medical education
- _____ For any purpose authorized by law.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

INITIAL THE
STATEMENT THAT
BEST REFLECTS
YOUR WISHES

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FURTHER INSTRUCTIONS:

ADD FURTHER
INSTRUCTIONS
(IF ANY)

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 decision making 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

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NEW JERSEY INSTRUCTION DIRECTIVE - PAGE 5 OF 5

**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 and 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

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

OR

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: (check one)

____ Notary Public

____ Attorney at Law

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You Have Filled Out Your Advance Directive, Now What?

1. Your *Advance Directive for Health care* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your representative and alternate representative, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your representative(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your document.
6. Be aware that your document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**