The Rest Of Your Life www.theroyl.com

Advance Directive and Durable Power of Attorney

Combined Advance Directive for Health Care (Combined Proxy and Instruction Directive)

State of New Jersey

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).

This form is from Advance Directives for Health Care: Planning Ahead for Important Health Care Decisions.

Combined Advance Directive for Health Care
(Combined Proxy and Instruction Directive)

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 concerning my care and will turn to someone who knows my values and health care wishes. I understand that those responsible for my care will seek to make health care decisions in my best interests, based upon what they know of my wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

I, EXAMPLE _____ hereby declare and make known my instructions and wishes for my future health care. This advance directive 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. I direct that this document become part of my permanent medical records.

In completing Part One of this directive, you will designate an individual you trust to act as your legally recognized health care representative to make health care decisions for you in the event you are unable to make decisions for yourself.

In completing Part Two of this directive, you will provide instructions concerning your health care preferences and wishes to your health care representative and others who will be entrusted with responsibility for your care, such as your physician, family members and friends.

Part One: Designation of a Health Care Representative

A) Choosing a Health Care Representative:

I hereby designate:

name_____

address_____

city_____state_____

telephone_____

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, or a situation arises I did not anticipate, my health care representative is authorized to make decisions in my best interests, based upon what is known of my wishes.

I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf.

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 order of priority stated:

1. name EXAMPLE_____ 2. name_____

address_____ address_____

city_____ state_____ city_____state_____

telephone_____ telephone_____

Part Two: Instruction Directive

In Part Two, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your health care representative, doctor and family members or others who may become responsible for your care.

In **Sections C and D***, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use* **Section E***, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment.* **Please familiarize yourself with all sections of Part Two before completing your directive.**

C) General Instructions. To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care.

Initial ONE of the following two statements with which you agree:

1. _____I direct that all medically appropriate measures be provided to sustain my life regardless of my physical or mental condition.

2. _____ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

If you have initialed statement 2, on the following page please initial each of the statements (a, b, c) with which you agree:

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a. _____I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and 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 measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medially appropriate care necessary to make me comfortable and relieve pain.

In the space provided, write in the bracketed phrase with which you agree:

To me, terminal condition means that my physicians have determined that:

_____
[I will die within a few days] [I will die within a few weeks]
[I have a life expectancy of approximately _____**or less** (enter 6 months or 1 year)**]**

b. ____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 capacity for interaction with other people and my surroundings, I direct that life-sustaining measures 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 care necessary to provide for my personal hygiene and dignity.

c. ____I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater that the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

*(Paragraph **c.** covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental or physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations, which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use **Section E** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

_____

_____

_____

_____

_____

D) Specific Instructions: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR). *On page 3 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures-artificially provided fluids and nutrition and cardiopulmonary resuscitation*.

In the space provided, write in the bracketed phrase with which you agree:

1. In the circumstances I initialed on page 3, I also direct that artificially provided fluids and nutrition, such as feeding tube or intravenous infusion,

_____
[be withheld or withdrawn and that I be allowed to die]
[be provided to the extent medically appropriate]

2. In the circumstances I initialed on page 3, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

_____
[not be provided and that I be allowed to die]
[be provided to preserve my life, unless medically inappropriate or futile]

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

_____

_____

_____

E) Additional Instructions: *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your health care representative, family members, or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

_____

_____

_____

F) Brain Death: *(The state of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard 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 solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

G) After Death-Anatomical Gifts: *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues, and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

Initial the statements which express your wishes:

1. ___**I wish** to make the following anatomical gift to take effect upon my death:

A. ___any needed organs or body parts.
B. ___only the following organs or parts

_____

for the purposes of transplantation, therapy, medical research or education, or

C. ___my body for anatomical study, if needed.
D.___special limitations, if any;

_____

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

_____

_____

_____

2. ___**I do not wish** to make an anatomical gift upon my death.

Part Three: Signature and Witnesses

H) Copies: The original or a copy of this document has been given to the following people (Note: *If you have chosen to designate a health care representative, it is important that you provide him or her with a copy of your directive):*

1. name EXAMPLE_____ 2. name_____

address_____ address_____

city_____state_____ city_____state_____

telephone_____telephone_____

I**) Signature:** By writing this advance directive, I inform those who may become entrusted with 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 and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this_____day of_____, 20_____.

signature EXAMPLE_____

address_____

city_____state_____

J) 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. 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.

1. witness_____

address_____

city_____state_____

signature_____

date_____

2. witness_____

address_____

city_____state_____

signature_____

date_____

New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care (The New Jersey Bioethics Commission) March 1991

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Additional Pages: