The Halachic Medical Directive

DURABLE POWER OF ATTORNEY/DECLARATION WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN CALIFORNIA

The "Halachic Medical Directive" is designed to help ensure that all medical and post-death decisions made by others on your behalf will be made in accordance with Jewish law and custom (*halacha*). The text of this Halachic Medical Directive has been approved by attorneys for use in your state as of November 2003. While we do not expect that any future change in federal or state laws would materially affect the validity of this document, you may wish to show it to your own attorney to confirm its effectiveness in subsequent years.

INSTRUCTIONS

(a) In Part 1, Section 1.1, print the name, address, and telephone numbers of the person you wish to designate as your agent to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own. Be sure to include all numbers (including cell phone and pager) where your agent can be reached in the event of an emergency. If the contact information for your agent changes, you should provide that updated information to everyone whom you have provided with a copy of your Halachic Medical Directive.

You may also insert the name, address, and telephone numbers of one or two alternate agent(s) to make such decisions if your primary agent is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your agent or alternate agent you should ascertain that person's willingness to serve in such capacity. In addition, if you have made arrangements with a burial society (Chevra Kadisha), you may wish to advise your agents of such arrangements.

Note: The supervising health care provider or an employee of the health care institution where you are receiving care, and the operator or an employee of a community care facility or residential care facility where you are receiving care, may not serve as a health care agent unless the person is related to you by blood, marriage, or adoption, or is your coworker.

(b) Your agent's authority becomes effective when your primary physician determines that you are unable to make your own health care decisions, unless you mark the box in Section 1.3. If you mark the box in Section 1.3, your agent's authority will take effect immediately upon the execution of the Halachic Medical Directive.

(c) In Part 2, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your agent to follow should any questions arise as to the requirements of *halacha*.

You should then print the name, address, and telephone numbers of the Orthodox Jewish institution or organization you want your agent to contact for a referral to another Orthodox Rabbi if the Rabbi you have identified is unable, unwilling or unavailable to provide the appropriate consultation and guidance.

You are, of course, free to insert the name of any Orthodox Rabbi or institution/ organization you would like, but before doing so it is advisable to discuss the matter with the Rabbi or institution/organization to ascertain their competency and willingness to serve in such capacity. You may list Agudath Israel of America as the organization you select; however, we are only available to be contacted on regular business hours and days.

(d) In Part 3, at the conclusion of the form, print the date, sign your name, and print your address.

(e) The form must be signed by two witnesses. The two witnesses should sign their names and insert their addresses beneath your signature. The witnesses should be age 18 or over and should be present when you sign or acknowledge your signature on the form. Neither of them should be the person you have appointed as your health care agent (or alternate agent), your health-care provider, an employee of your health-care provider, or the operator or employee of a residential care facility for the elderly. At least one of the witnesses must be a person who is NEITHER related to you by blood, marriage, or adoption, NOR entitled to any portion of your estate upon your death under a will now existing or by operation of law. Additionally, each witness must make a declaration as written in the form, stating that they comply with the requirements. The witness declarations are found in Sections 3.3 and 3.4. **Please note that if you are a patient in a skilled nursing facility, a patient advocate or ombudsman designated by the State Department of Aging must also sign the form and must declare that he or she is serving as a witness as required by law.** This additional witness requirement is found in Part 4.

(f) It is recommended that you keep the original of this form among your valuable papers in a location that is readily accessible in the event of an emergency, and that you **distribute copies to the health care agent (and alternate agent)** you have designated in Part 1, **to the Rabbi and institution/organization** you have designated in Part 2, as well as to **your doctor, your lawyer**, and anyone else who is likely to be contacted in times of emergency. We also recommend that you register a copy of this form with a national registry, so that it can be accessed by any health care facility via computer. Agudath Israel has made an arrangement with the New York Legal Assistance Group to register Halachic Medical Directives for our constituents with the U.S. Living Will Registry at no charge. To obtain the forms to enable you to do so, e-mail CAdirective@agudathisrael.org or call our office (212-797-9000).

(g) If at any time you wish to revoke the designation of an agent, you may do so only by a signed writing or by personally informing your supervising health-care provider. You may revoke all or part of this Halachic Medical Directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke. If you do revoke it, to avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Halachic Medical Directive and destroy them.

If you do not revoke this Halachic Medical Directive, it will remain in effect indefinitely. Obviously, if any of the persons whose names you have inserted in this form dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new form.

(h) It is recommended that you also complete and cut out the **Emergency Instructions Card** contained on the last page of this Halachic Medical Directive, and carry it with you in your wallet or purse.

(i) If, upon consultation with your Rabbi, you would like to add to this Halachic Medical Directive any additional expression of your wishes with respect to medical and/or post-mortem decisions, you may do so by attaching a rider to the standardized form. If you choose to do so, or if you have any other questions concerning this form, please consult an attorney.

These instructions are not part of the Halachic Medical Directive and need not be kept attached to the executed document.

Developed and published by: Agudath Israel of America • 42 Broadway, 14th Floor • New York, NY 10004 • 212-797-9000

CALIFORNIA
ADVANCE HEALTH CARE DIRECTIVE

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

Agent

Name of Agent: _____

Address: _____

_____

Telephone:
Day:_____ Evening: _____

Cell:_____ Pager/beeper:_____

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

First Alternate Agent

Name of First Alternate Agent:
_____

Address: _____

_____

Telephone:
Day:_____ Evening: _____

Cell:_____ Pager/beeper:_____

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Second Alternate Agent

Name of Second Alternate Agent:
_____

Address: _____

_____

Telephone:
Day:_____ Evening: _____

Cell:_____ Pager/beeper:_____

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, consistent with the specifications described in Part 2.

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POST-DEATH AUTHORITY: It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters. I further direct that my agent be responsible for the disposition of my remains.

Further, subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post-mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the agent and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes. Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in Section 2.2 of Part 2, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

(2.1) JEWISH LAW TO GOVERN HEALTH CARE DECISIONS: I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me (whether made by my agent, a guardian appointed for me, or any other person) be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

(2.2) ASCERTAINING THE REQUIREMENTS OF JEWISH LAW: In determining the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with the following Orthodox Rabbi and I ask my agent to follow his guidance:

Rabbi Name of Rabbi:_____

Address:_____

_____

Telephone: Day: Evening:

_____ _____

Cell: Pager/beeper:

_____ _____

If such Orthodox Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, the following Orthodox Rabbi:

Rabbi Name of Rabbi:

_____

Address:

_____

Telephone: Day: Evening:

_____ _____

Cell: Pager/beeper:

_____ _____

If both of these Orthodox Rabbis are unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

Organization Name of Institution/Organization:

_____

Address: _____

_____

Telephone: Day: _____ Evening: _____

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my agent to consult with, and I ask my agent to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my agent in good faith believes I would respect and follow.

(2.3) DIRECTION TO HEALTH CARE PROVIDERS: Any health care provider shall rely upon and carry out the decisions of my agent, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my agent has not acted in good faith in accordance with my wishes as expressed in this advance health care directive.

If the persons designated above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined above in Section 2.2 in determining the requirements of Jewish law and custom.

Pending contact with the agent and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

(2.4) ACCESS TO MEDICAL RECORDS AND INFORMATION; HIPAA: My agent is my personal representative, as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and accordingly all of my protected health information (as such term is defined under HIPAA) and other medical records shall be made available to my agent upon request in the same manner as such information and records would be released and disclosed to me, and my agent shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records, as required under HIPAA.

(2.5) INCONTROVERTIBLE EVIDENCE OF MY WISHES: If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated above in Section 1.1 as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined above in Section 2.2 should be followed in determining the requirements of Jewish law and custom.

(2.6) DURATION AND REVOCATION: It is my understanding and intention that unless I revoke this proxy and directive, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a revocation of any prior health care proxy, directive or other similar document I may have executed prior to today's date.

PART 3: SIGNATURE AND WITNESSES

(3.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(3.2) SIGNATURE: Sign and date the form here:

My Signature

Signature: _____

(If you are not physically capable of signing, please ask another person to sign your name on your behalf.)

Print Name: _____

Date: _____

Address: _____

_____

Telephone: Day: _____ Evening: _____

(3.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

Witnesses

Witness 1 Signature: _____

Printed Name: _____

Residing at: _____

Date: _____

Witness 2 Signature: _____

Printed Name: _____

Residing at: _____

Date: _____

(ONE OF THESE WITNESSES MUST ALSO SIGN THE STATEMENT ON THE NEXT PAGE)

Part 3 (Continued):

(3.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

Witness 1 or 2 Signature: _____

Print name: _____

PART 4

SPECIAL WITNESS REQUIREMENT

The following statement is required **only** if you are a patient in a skilled nursing facility--a health care facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

Special Witness Signature: _____

Printed Name: _____

Residing at: _____

_____

Date: _____

Emergency Instructions

I_____, have executed a "Halachic Medical Directive" with respect to medical and post-mortem decisions, dated_____. Pursuant to the "Halachic Medical Directive" the persons listed on the reverse of this card are to serve as my agent and alternate agent, respectively, in making health care decisions for me if I become unable to do so on my own. I desire that all such health care decisions, as well as all decisions relating to the handling and disposition of my body after I die, should be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. If there is any questions regarding Jewish law and custom, my agent (or any other person making decisions for me) should consult with and follow the guidance of the rabbi identified on the reverse of this card, or as a second choice the rabbi referred by the institution/organization identified on the reverse of this card, or as a third choice an Orthodox Rabbi whose guidance my health care decision maker in good faith believes I would respect and follow. Pending contact with my agent and/or rabbi, I desire that health care providers should undertake all essential emergency measures on my behalf; and I desire that no autopsy, organ removal, or other post mortem procedure be performed on my body without authorization from my agent and/or rabbi.

Fold on the dotted line to create a double sided card

EMERGENCY INSTRUCTIONS

Agent: _____
Phone_____
Evening: _____Cell: _____
Alternate Agent: _____
Phone: _____
Evening: _____Cell: _____
Rabbi:_____
Phone:_____
Evening: _____Cell_____
Organization_____ Phone: _____

Agudath Israel of America
אגודת ישראל באמריקה

Agudath Israel of America, in partnership with the New York Legal Assistance Group (NYLAG) would like to encourage you to register your Halachic Medical Directive for free with the U.S. Living Will Registry®. The Registry will maintain a copy of your Halachic Medical Directive on a secure website that can be accessed instantly by any health care facility. We encourage registration because in many cases, a patient has to be rushed to a hospital and the family cannot locate the Halachic Medical Directive. The Registry solves this problem and therefore ensures that your health care wishes will be respected. (If you were to register on your own, there is a cost for the service. However, if you register through NYLAG, this service is provided at no cost.)

Benefits of registration are:

1. The U.S Living Will Registry® provides a wallet-sized card with your special identification number. The information on that card allows for a medical professional to view your Halachic Medical Directive at any time of the day or night. This provides peace of mind to yourself and your loved ones. No one will have to search for these vital documents should you become incapacitated since the only information the health care facility needs is readily available in your wallet or purse.
2. The U.S Living Will Registry® issues a new card every twelve months. This will allow you to remember to update any new information (change in telephone numbers, addresses or even change of appointed Health Care Proxy.)

To register your Halachic Medical Directive, all you need to do is complete the U.S. Living Will Registry Registration Agreement (attached.) Please note that if you do not feel comfortable providing your Social Security Number, you do not have to do so.

Please attach a clear copy of your Halachic Medical Directive to the U.S. Living Will Registry Registration Agreement, and send both documents to:

New York Legal Assistance group
Total Life Choices Program
7 Hanover Square
New York, NY 10004

Or fax them to **(212) 750-0820**

Information about the New York Legal Assistance Group may be found at: www.nylag.org
Information about the U.S. Living Will Registry® may be found at: www.uslivingwillregistry.com

THE RABBI MOSHE SHERER NATIONAL HEADQUARTERS
42 Broadway • New York, NY 10004 • 212-797-9000 • Fax: 646-254-1600

U.S. Living Will Registry®
Registration Agreement

Source Code
37125901

Registrant's Identifying Information (Please type or print clearly)

Name: First_____ Middle_____Last _____ Suffix _____

Social Security Number:_____ _____ _____Date of Birth: Month ___Day____Year_____(4 digits, please)

Address - Primary Residence: Street Address _____ Apt #_____

City _____ State _____ Zip Code _____

Secondary Residence (if any): Street Address_____Apt #_____

City _____ State_____ Zip Code _____

Phone- Home: ( ) _____ Work: ( )_____Secondary Res: ( )_____

Emergency Contact #1: Name:_____Relationship:_____

Address:_____

Telephone Number: Home: ( )_____Work/Other: ( )_____

Emergency Contact #2: Name:_____Relationship:_____

Telephone Number: Home: ( )_____Work/Other: ( )_____

I,_____ ("Registrant" or "I"), request that the *U.S. Living Will Registry®*, with offices at 523 Westfield Ave., PO Box 2789 Westfield, New Jersey 07091-2789 ("Registry"), electronically store a copy of my attached advance directive (collectively, including but not limited to my: living will, health care proxy, or similar document[s], including organ donor information, provided to the Registry), and provide a copy of the stored advance directive image to any health care provider who requests it in conjunction with my care. A "health care provider" is any hospital, doctor, skilled nursing facility, nursing facility, home health care agency/provider, ambulatory surgery facility, hospice, or any authorized employee, contractor or agent of any of the foregoing, or other person believed charged with giving effect to my advance directive or assisting in same. I voluntarily execute this registration on the date set forth below, without coercion, duress or undue influence from any party, and I warrant and represent that I have the legal capacity to offer my consent to such registration. My registration is not effective until I receive written confirmation from the Registry, at the above address. I can only register through a Registry member Health Care Provider or a Registry Community Partner. The Registry's member Health Care Providers and Community Partners are not owned or operated by the Registry, and they cannot change any terms of this Registration Agreement; any oral changes are not effective. Only the Registry can change the terms of the Registration Agreement, and only in writing (except in emergencies, in the Registry's sole discretion). I have provided my Social Security number to facilitate the identification, retrieval and provision of my stored advance directive images to health care providers, and for the Registry's recordkeeping purposes only.

I. Registration and Certification: I submit the information contained herein to confirm my identity, in the event that a health care provider requests a copy of my advance directive. I certify that this information is correct and that the attached advance directive is my currently effective advance directive, which was properly executed in accordance with the laws of the state where it was executed. If the attached advance directive is a copy, I certify that it is a true and correct copy of the

original document. I agree to immediately notify the Registry, in writing, at the Registry's address listed above, in the event of my revocation of the attached advance directive or of this registration, or if the attached advance directive or the identifying information herein are changed in any way. I agree immediately to provide the Registry with a copy of the new/changed documents. I will indemnify and hold the Registry harmless for any damages resulting from the Registry's reliance on these certifications, or on any inaccurate information I supplied. If I don't notify the Registry in writing and in a timely manner of any changes, or of the revocation of my advance directive or this registration, or if I don't provide a true copy of the changed documents to the Registry, the Registry will not be liable for any damages resulting from the production of the documents on file to any health care provider. If my information is accessed over the Internet utilizing my unique registration number, my social security number ("SSN") will not be revealed, and it will not be visible or disclosed on the Registry's web page. If the card containing my unique registration number is lost or otherwise unavailable, health care providers will be able to access my documents using my SSN. Since most health care providers have access to their patients' SSN, providing your SSN to the Registry ensures the widest availability of your advance directive images to health care providers in time of need, even when your card is not available. The Registry will take appropriate steps to safeguard the privacy and confidentiality of each Registrant's SSN, and the Registry will not use SSNs for any purposes not specifically permitted by this Registration agreement. If you do not provide your SSN, your documents will be identified only by the unique registration number assigned by the Registry, which will significantly limit the accessibility of your documents.

II. Authorization: I authorize the Registry to send a copy of my advance directive to any health care provider (as defined herein) that requests a copy of it, provided the request conforms to the Registry's policies and procedures (or as deemed advisable by the Registry in an emergency situation, or as required by law). The Registry is not otherwise authorized to share my personal information with parties other than health care providers (as defined herein). A copy of this Agreement may be used in place of the original document.

III. Limitations on Liability: I understand that I will not be charged a fee to register or to maintain my registration. Registry shall not be liable to me or any person or entity for any liability arising from the improper transmission/disclosure of my advance directive, from the transmission of inaccurate or incomplete materials, or from the loss/misplacement/destruction/unavailability of all or part of my advance directive. If I don't agree to these terms, I am free not to use the Registry's service.

IV. Term: This Agreement shall remain in effect until Registry receives reliable information that the Registrant is deceased, the Registrant requests, in writing, that the Agreement be terminated, or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, Registry will use best efforts to remove Registrant's advance directive from its files.

I hereby agree to the terms herein, and certify the accuracy of the information provided. I agree to safeguard my Registration ID card from unauthorized access. I understand that anyone who gains access to my card can use it to gain access to my documents and personal information (but not to my SSN), and I will not hold the Registry liable for such unauthorized access.

X_____ **DATED:** _____/_____/_____

Signature of Registrant

WITNESS STATEMENT

I declare that the Registrant who signed this document is personally known to me, that he/she signed or acknowledged this document in my presence, and that he/she appears to be of sound mind, and under no duress or undue influence.

Signature: _____Print Name: _____

(Witness #1) DATED: _____/_____/_____

Signature: _____Print Name: _____

(Witness #2) DATED: _____/_____/_____