

The Halachic Medical Directive

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

FOR USE IN GEORGIA

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 July, 2005. 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. You must be an individual 18 years of age or older who is of sound mind at the time you execute this document.

INSTRUCTIONS

(a) **Please print your name on the first line of the form.**

(b) **In section 1, print the name, address, and day and evening 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..

You may also insert the name, address, and telephone numbers of a successor agent to make such decisions if your main agent is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your agent or successor 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*) for the handling and disposition of your body after death, you may wish to advise your agents of such arrangements.

Note: *Georgia law allows virtually any competent adult* (an adult is a person 18 years of age or older) *to serve as an agent*. Thus, you may appoint as your agent or successor agent your spouse, adult child, parent or other adult relative. You may also appoint a non-relative to serve as your agent (or successor agent). However, you may not appoint as your agent a health care provider who may be directly or indirectly involved in rendering health care to you under this Durable Power of Attorney for Health Care.

(c) **In section 3, 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 section 8, sign and print your name, address, phone numbers, and the date before two witnesses.** If you are not physically able to do these things, Georgia law allows another person to sign and date the form on your behalf, as long as he or she does so *at your direction, in your presence and in the presence of the two witnesses.*

The two witnesses must be competent adults (18 years or older). *Neither of them should be the person you have appointed as your agent or successor agent.* They may, however, be your relatives.

(e) **In the DECLARATION OF WITNESSES section beneath your signature, the date should be inserted and the two witnesses should sign their names and insert their addresses beneath their signature.**

(f) **IF YOU ARE A PATIENT IN A HOSPITAL OR SKILLED NURSING FACILITY, the Durable Power of Attorney for Health Care must also be witnessed by your attending physician, who should date and sign the ATTENDING PHYSICIAN ATTESTATION below the Declaration of Witnesses section.**

(g) It is recommended that you keep the original of this form among your valuable papers; and that you **distribute copies to the agent (and successor agent)** you have designated in section 1, **to the rabbi and institution/organization** you have designated in section 3, as well as to **your doctors, 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 Directive 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 GAdirective@agudathisrael.org or call our office (212-797-9000).

(h) **If at any time you wish to revoke this Durable Power of Attorney for Health Care, you may do so by destroying it, by a written revocation which is signed and dated by you or by someone else at your direction, by an oral or other expression of your intent to revoke it before a competent witness who confirms such expression in a dated and signed writing within 30 days of your expression, or by executing a new copy of this form.** By law, your marriage after the execution of this Durable Power of Attorney for Health Care automatically revokes any designation of an agent other than a designation of your spouse. Also, an appointment of your spouse as your agent is automatically revoked upon divorce or dissolution of your marriage.

If you do not revoke the Durable Power of Attorney for Health Care, Georgia law provides that it remains in effect indefinitely. Obviously, if any of the persons you have appointed in the Durable Power of Attorney for Health Care dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new Durable Power of Attorney for Health Care.

(i) 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.

(j) If, upon consultation with your rabbi, you would like to add to this standardized Durable Power of Attorney for Health Care 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.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

FOR USE IN GEORGIA

I, _____, hereby declare as follows:

1. Appointment of Agent: In recognition of the fact that there may come a time when I will become unable to make my own health care decisions because of illness, injury or other circumstances, I hereby appoint

Agent

Name of Agent:

Address:

Telephone: Day:

Evening:

as my agent (“agent”) to make any and all health care decisions for me, consistent with my wishes as set forth in this directive.

If the person named above is unable, unwilling or unavailable to act as my agent, I hereby appoint

*Successor
Agent*

Name of Successor Agent:

Address:

Telephone: Day:

Evening:

to serve in such capacity.

This appointment shall take effect in the event I become unable, because of illness, injury or other circumstances, to make my own health care decisions.

2. 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 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.

3. 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: _____

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 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.

4. 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 directive.

If the persons designated in section 1 above as my agent and successor 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 in section 3 above 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.

5. 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.

6. Post-Mortem Decisions: 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.

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 paragraph 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

7. 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 in section 1 above as my agent and successor 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 in section 3 above should be followed in determining the requirements of Jewish law and custom.

8. 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.

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:

DECLARATION OF WITNESSES

I, being over 18 years of age, declare that the person who signed (or asked another to sign) this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He/She signed (or asked another to sign for him/her) this document in my presence (and that person signed in my presence) and in the presence of the other witness.

Witnesses

Witness 1:

Signature _____

Print Name _____

Residing at:

Witness 2:

Signature _____

Print Name _____

Residing at:

ONLY IF YOU ARE SIGNING THIS DOCUMENT IN A HOSPITAL OR A SKILLED NURSING FACILITY, YOUR ATTENDING PHYSICIAN MUST SIGN BELOW.

ATTENDING PHYSICIAN ATTESTATION

I, on this _____ day of _____, 20__, hereby witness this Durable Power of Attorney for Health Care and attest that I believe the person who signed (or asked another to sign) this document to be of sound mind and to have made this Durable Power of Attorney for Health Care willingly and voluntarily.

*Attending
Physician*

Signature: _____

Print Name _____

Residing at:

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, 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: ____/____/____