The Halachic Medical Directive

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

FOR USE IN OHIO

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 January, 2006. 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) Please read the required statutory notification and then print your name on the first line of the form (on page five, immediately following the notification).

(b) In section 2, print the name, address, and telephone numbers of the person you wish to designate as your agent (known under Ohio law as your "attorney in fact") 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 attorney in fact can be reached in the event of an emergency. If the contact information for your attorney in fact 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 an alternate attorney in fact to make such decisions if your primary attorney in fact is unable, unwilling, or unavailable to make such decisions.

It is recommended that before appointing anyone to serve as your attorney in fact or alternate attorney in fact 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 attorney in facts of such arrangements.

Note: This form is effective only if you and your attorney in fact(s) are competent adults (18 years old or older). Your attending physician or an administrator of any nursing home in which you are receiving care may not serve as a health care attorney in fact. An employee of your attending physician or an employee or agent of any health care facility in which you are being treated may not serve as your health care attorney in fact unless the person is related by blood, marriage or adoption to you.

(c) In section 4, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your attorney in fact 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 attorney in fact 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, are only available on regular business hours and days.

(d) At the conclusion of the form, print the date, sign your name, and print your address and telephone number.

(e) The form must be either witnessed by two witnesses or acknowledged by a notary public.

i. If witnessed: Two witnesses should insert the date at the top of the Declaration of Witnesses and, after reading the Declaration, sign their names and print their addresses after the Declaration. These witnesses must be adults. Neither of them should be the person you have appointed as your health care attorney in fact (or alternate attorney in fact), your relative by blood, marriage, or adoption, or your attending physician or the administrator of any nursing home in which you are receiving care.

ii. If acknowledged: a Notary Statement is included in the form.

(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 attorney in fact (and alternate attorney in fact)** you have designated in section 2, **to the Rabbi and institution/organization** you have designated in section 4, 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 OHdirective@agudathisrael.org or call our office (212-797-9000).

(g) If at any time you wish to revoke this Halachic Medical Directive, you may do so by destroying or defacing the document or by signing and dating a written statement which expresses your intent to 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 the Halachic Medical Directive 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 standardized form 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

Health Care Power Of Attorney

FOR USE IN OHIO

Notice to Adult Executing This Document:

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make most health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other heath care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make heath care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact generally will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you generally will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

However, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact never will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could

refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (**You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);**

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:

(a) You are in a terminal condition or in a permanently unconscious state.

(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.

(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:

(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;

(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.

(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the requirements of (4)(c)(i) and (ii) above.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact generally will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you cannot designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you cannot designate an employee or attorney in fact of your attending physician, or an employee or attorney in fact of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or attorney in fact is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or attorney in fact is a competent adult and you and the employee or attorney in fact are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

I, _____, hereby declare as follows:

1. **Attorney in Fact Requirements**:

My attorney in fact and my alternative attorney in fact are at least 18 years of age and are **NOT**:

- my attending physician or administrator of a nursing home in which I am receiving care;
- an employee or agent of my attending physician and an employee or agent of any health care facility in which I am being treated unless he or she is related to me by blood, marriage or adoption or is a member of my same religious order.

2. **Appointment of Attorney in Fact**: In recognition of the fact that there may come a time when I will become unable to make my own health care decisions due to illness, injury or other circumstances, I hereby appoint

Attorney in Fact

Name of Attorney in Fact:
_____

Address:
_____

Telephone: Day: _____ Evening:_____

Cell: _____ Pager/beeper: _____

as my health care attorney in fact 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 attorney in fact or is divorced or legally separated from me or is dead, I hereby appoint

Alternate Attorney in Fact

Name of Alternate Attorney in Fact:
_____

Address:
_____

Telephone: Day: _____ Evening:_____

Cell: _____ Pager/beeper: _____

to serve in such capacity.

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

3. **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 attorney in fact, 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. *IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION IS MADE THAT NUTRITION OR HYDRATION WILL NOT OR WILL NO LONGER SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN, I SPECIFICALLY AUTHORIZE MY ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO ME, PROVIDED THAT MY ATTORNEY IN FACT SHALL ONLY EXERCISE SAID AUTHORITY IF SUCH REFUSAL OR WITHDRAWAL OF INFORMED CONSENT IS IN ACCORDANCE WITH THE REQUIREMENTS OF JEWISH LAW AS DETERMINED IN THE MANNER SET FORTH IN SECTION 4 BELOW, AND I ALSO SPECIFICALLY AUTHORIZE MY ATTORNEY IN FACT TO REQUEST OR GRANT OR CONTINUE CONSENT TO THE PROVISION OF NUTRITION AND HYDRATION.* _____ (initial here) Additionally, I explicitly grant my attorney in fact full power to order, if it is ascertained to be in accordance with Jewish Law, the performance or non-performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance or discontinuance of any particular course of life-sustaining medical treatment or other form of life-support maintenance; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

4. **Ascertaining the Requirements of Jewish Law**: If questions arise as to the requirements of Jewish law and custom in connection with this declaration, I direct my attorney in fact to consult with the following Orthodox Rabbi and I ask my attorney in fact 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 rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my attorney in fact to consult with, and I ask my attorney in fact to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my attorney in fact in good faith believes I would respect and follow.

5. **Direction to Health Care Providers**: Any health care provider shall rely upon and carry out the decisions of my attorney in fact, and, unless such health care provider has good cause to believe that my attorney in fact has not acted in good faith, shall assume that such decisions reflect my wishes and are the result of my attorney in fact's good faith execution of the procedures set forth in this directive.

If the persons designated as my attorney in fact and alternate attorney in fact in section 2 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 4 if any questions of Jewish law and custom should arise.

Pending contact with the attorney in fact and/or 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.

6. **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.

7. **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, and without in any way limiting the generality of the foregoing, I wish that Jewish law and custom guide the decisions made in matters such as the existence of exceptional circumstances that permits an exception to the general Jewish law prohibition against autopsies or dissections; the permissibility of the removal and usage of any of my body organs or tissue for transplantation purposes; the preparations for burial and the need for expeditious burial. I further direct that my agent be responsible for the disposition of my remains.

As time is of the essence with regard to these questions, I direct that any health care provider in attendance at my death notify the attorney in fact and/or 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, it is my desire, and I hereby direct, that no autopsy, dissection or other post-mortem procedure be performed on my body.

8. **Anatomical gift provision (optional):**

[Under Ohio law, printed health care power of attorney forms such as this one must now include an option to make an anatomical gift such as an organ donation, and must include an organ donor registry form. **You are under no legal obligation to make an organ donation. If you wish to do so, we urge you to discuss the matter with your Rabbi first, as the issue of organ donations may raise certain questions under Jewish law.** If you leave this section blank, you are not authorizing organ donation.]

Anatomical gift: Upon my death, the following are my directions regarding donation of all or part of my body:

I hereby give the following body parts:

_____

___for any purpose authorized by law: transplantation, therapy, research, or education OR

__for the following purposes only:_____

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

9. **Incontrovertible Evidence of My Wishes**: If for any reason this instrument is deemed not legally effective as a health care proxy, or if the persons designated as my attorney in fact and alternate attorney in fact in section 2 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 procedures in section 4 should be followed if questions of Jewish law and custom arise.

10. **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 instrument shall be deemed to constitute a revocation of any prior health care proxy, directive or other similar instrument I may have executed prior to this date.

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this instrument. I have read and understand the information contained in the disclosure statement.

My Signature

Signature:_____

Print Name: _____

Address:_____

DECLARATION OF WITNESSES

I, on this ____ day of _____, 20__, declare under penalty of perjury that the person who signed or acknowledged this instrument appointing a health care attorney in fact and expressing wishes regarding health care decisions (hereafter "principal") is personally known to me, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, and that the principal appears 18 years of age or older.

I also declare that I am at least 18 years of age and am **NOT** the individual appointed as health care attorney in fact by this instrument; the principal's attending physician; the administrator of any nursing home in which the principal is receiving care; or related to the principal by blood, marriage, or adoption.

Witness 1

Signature of Witness 1:_____

Printed Name of Witness 1: _____

Address: _____

Telephone: Day : _____ Evening :_____

Witness 2

Signature of Witness 2:_____

Printed Name of Witness 2: _____

Address: _____

Telephone: Day : _____ Evening :_____

THIS DOCUMENT MAY BE NOTARIZED INSTEAD OF WITNESSED; SEE NEXT PAGE

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(TO BE USED IN LIEU OF WITNESSES)

STATE OF OHIO)
:ss.:
COUNTY OF)

On this _____day of _____, in the year ,

before me, _____, personally
(insert name of notary public)
appeared _____, personally known to me
(insert name of principal)

(or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be sound of mind and under no duress, fraud, or undue influence.

NOTARY SEAL

_____
(signature of notary public)

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

Donor registry form

[Ohio law now requires that printed health care power of attorney forms such as this one include the following organ donor registry form. **You are under no legal obligation to make an organ donation. If you wish to do so, we urge you to discuss the matter with your Rabbi first, as the issue of organ donations may raise certain questions under Jewish law.** If you leave this section blank, you are not authorizing organ donation.]

Only if you wish to register for the Ohio Donor Registry or have your name removed from the Ohio Donor Registry, please complete this form and send it to the Ohio Bureau of Motor Vehicles. This form must be signed by two witnesses. If the donor is under age eighteen, one witness must be the donor's parent or legal guardian.

___Please include me in the donor registry.

___Please remove me from the donor registry.

Full Name (please print) _____
Mailing address _____
_____

Phone _____Date of Birth _____
Driver License or ID Card No. _____
Social Security No. _____

___On my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

OR

___On my death, I make an anatomical gift of the following specified organs, tissues, or eyes for any purposes indicated below.

Purposes:
__Any purpose authorized by law
__ Transplantation
__ Therapy
__Research
__Education
__Advancement of medical science
__Advancement of dental science

_____Signature of donor registrant

Date: _____

Witness signature: _____

Witness signature: _____

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: _____/_____/_____