The Halachic Medical Directive

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

FOR USE IN ILLINOIS

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) Please print the date of execution of this form on the first line of the form (on page two, immediately following the required statutory notification).

(b) In section 1, print your name.

Note: This form is effective only if you are a competent adult (an adult is a person 18 years of age or older).

(c) Then, print the name, address, and telephone numbers of the person you wish to designate as your agent (known under Illinois 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 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 an alternate agent to make such decisions if your primary agent is unable, unwilling, or unavailable to make such decisions. This is accomplished in section 5.

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: You may appoint any competent adult to serve as your health care agent, **except** your attending physician or a person who is administering health care to you.

(d) In section 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.

(e) Your agent's authority will become effective at the time this Halachic Medical Directive is signed, **unless** you initial the box in **section 3**. If you initial this box, you must also insert a future date or an event, such as your physician or a court determination of your disability, when you want this power to first take effect. You may also limit the duration of your agent's authority by initialing and completing the box in section 4.

(f) You may wish to name your agent as guardian of your person, should a court decide that one should be appointed. This is accomplished in section 6. If you do not wish to name your agent as guardian, strike out section 6.

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

(h) Two witnesses should sign their names and insert their addresses beneath your signature. The witnesses must be competent and 18 years old or older.

(i) You may, but are not required, to request that your agent and alternate agent provide specimen signatures on the last page of the form.

(j) You or your agent should notify your health care provider of the existence of this Halachic Medical Directive and of any amendment or revocation. 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 sections 1 and 5, **to the Rabbi and institution/organization** you have designated in section 2, as well as to **your doctor, your lawyer**, and anyone else who is likely to be contacted in times of emergency.

(k) 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. This can be done for a fee by contacting the U.S. Living Will Registry at http://www.uslivingwillregistry.com or by calling 1-800-548-9455.

(l) If at any time you wish to revoke this Halachic Medical Directive, you may do so by destroying or defacing the document in a manner which indicates your intention to revoke it, by signing and dating a written revocation (or by directing another person to do so on your behalf) or by making an oral revocation in the presence of an adult witness who signs and dates a writing confirming that such expression of intent was made. 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, subject to any limitation in section 4. Obviously, if any of the persons whose names you have inserted in the form dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new Halachic Medical Directive.

You may amend the Halachic Medical Directive by a written amendment signed and dated by you, or by a person acting at your direction.

(m) 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.

(n) If, upon consultation with your Rabbi, you would like to add to this standardized Living Will and 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

Illinois Statutory Short Form
Power of Attorney For Health Care

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME OR OTHER INSTITUTION. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT WHEN POWERS ARE EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM AND KEEP A RECORD OF RECEIPTS, DISBURSEMENTS AND SIGNIFICANT ACTIONS TAKEN AS AGENT. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME SUCCESSOR AGENTS UNDER THIS FORM BUT NOT CO-AGENTS, AND NO HEALTH CARE PROVIDER MAY BE NAMED. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW, UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN SECTIONS 4-5, 4-6, 4-9 AND 4-10(b) OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW" OF WHICH THIS FORM IS A PART. THAT LAW EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

POWER OF ATTORNEY made this _____day of _____, 20___.

1. I, _____, hereby appoint:

Agent Name of Agent:

_____

Address:

_____

_____

Telephone: Day: Evening:

_____ _____

Cell: Email Address

_____ _____

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains.

(THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF FOOD AND WATER AND OTHER LIFE-SUSTAINING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES OR LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.):

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.

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: Telephone: Evening:

_____ _____

Cell Phone: Email Address:

_____ _____

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: Email Address:

_____ _____

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.

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 as my agent and alternate agent (in sections 1 and 5 respectively) 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 this section 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.

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.

Post-Mortem Decisions: It is 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 hereby willfully and voluntarily make known my desire that, in the event of my death, the disposition of my remains shall be controlled by my agent designated in section 1 above. In the event my agent is unable, unwilling or unavailable to act, I hereby appoint the alternate agent designated in section 1 above to control 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 above in this section, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

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 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 this section should be followed in determining the requirements of Jewish law and custom.

(THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW". ABSENT AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH, AND BEYOND IF ANATOMICAL GIFT, AUTOPSY OR

DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:)

3. ( ) This power of attorney shall become effective on _____, 20__.

(insert a future date or event during your lifetime, such as court determination of your disability, when you want this power to first take effect)

4. ( ) This power of attorney shall terminate on _____, 20__.

(insert a future date or event, such as court determination of your disability, when you want this power to terminate prior to your death)

(IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING SECTION.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following as successor to such agent:

Alternate Agent

Name of Alternate Agent:

_____

Address:

_____

_____

Telephone: Day: Evening:

_____ _____

Cell: Email Address

_____ _____

For purposes of this section 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(IF YOU WISH TO NAME YOUR AGENT AS GUARDIAN OF YOUR PERSON, IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO DO SO BY RETAINING THE FOLLOWING SECTION. THE COURT WILL APPOINT YOUR AGENT IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. STRIKE OUT SECTION 6 IF YOU DO NOT WANT YOUR AGENT TO ACT AS GUARDIAN.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

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:

_____

_____

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

Witnesses Witness 1:

Signature _____

Print Name _____

Residing at:

_____

Witness 2

Signature_____

Print Name _____

Residing at

_____

_____

(YOU MAY BE REQUIRED TO REQUEST THAT YOUR AGENT AND ALTERNATE AGENT PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION BELOW THE SIGNATURES OF THE AGENTS.) Specimen signatures of agent (and alternate).

Agent Signatures

Agent's Signature:

_____

Alternate Agent's Signature:

_____

Your Certification

I certify that the signatures of my agent and alternate agent are correct:

Signature:

_____

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

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: _____