ADVANCE HEALTH CARE DIRECTIVE AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, _____, a resident of the County of _____, Missouri, declare this instrument to be my Advance Health Care Directive and Durable Power of Attorney for Health Care Decisions.

I. ADVANCE HEALTH CARE DIRECTIVE

A. Statement of Intent: I have the primary right to make my own decisions concerning my medical treatment. In the event that I am unable to exercise this right in the future because I am unable to participate in decisions regarding my medical treatment, I hereby voluntarily and willingly make this declaration, at a time when I am of sound mind and over eighteen years of age, to express to my physician, my family, and my friends my intents regarding my medical treatment under the circumstances set forth below.

B. Jewish Law to Govern my Health Care Decisions: I am Jewish. It is my desire, and I hereby direct, that all my health care decisions made for me be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. By way of example, and 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 or non-performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the initiation or discontinuance of any particular course of medical treatment or other form of life-support maintenance, including tube-delivered nutrition and hydration; and the method and timing of determination of death.

C. Ascertaining the Requirements of Jewish Law: In order to effectuate my wishes, if any question arises as to the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with and follow the guidance of the following Orthodox Rabbi:

1. Name of Rabbi: _____
Address: _____
_____
Telephone: Day _____ Evening _____

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

2. Name of Rabbi: _____
Address: _____
_____
Telephone: Day _____ Evening _____

In the event that such Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with and follow the guidance of an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

3. Name of Institution/Organization: _____
Address: _____

_____

Telephone: Day _____ Evening _____

In the event that 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 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.

D. 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.

If the persons designated as my agent or alternate agents 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 Paragraph C above.

Pending contact with the agent 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.

E. 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. By way of example, and without limiting in any way the generality of the foregoing, it is my wish that there be conformance with Jewish law and custom with respect to such matters and questions as whether there exist exceptional circumstances that would permit an exception to the general prohibition under Jewish law against the performance of an autopsy or dissection of my body; the permissibility or non-permissibility of the removal and usage of any of my body organs or tissue for transplantation purposes; and the expeditious burial of my body and all preparations leading to burial.

Time is of the essence with regard to these questions. I therefore direct that any health care provider in attendance at my death notify my agent and/or the 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 postmortem procedure be performed on my body.

F. Incontrovertible Evidence of My Wishes: If, for any reason, this document is deemed not legally effective as a health care directive, or if the persons designated as my agent and alternate agents are unable, unwilling, or unavailable to serve in such a capacity, I declare to my family, my doctor and anyone else who 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 Paragraph C above should be followed when questions of Jewish law and custom arise.

G. 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 directive, proxy, living will, or similar document I may have executed prior to today's date.

II. DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

A. Appointment of Agent: In order to implement my intentions expressed herein, I appoint (name) _____, (address) _____ _____, (telephone) _____ as my true and lawful agent, to act for me and in my name to make health care decisions in the event I am incapacitated as defined herein. If my agent appointed herein resigns, dies or becomes incompetent, then I appoint (name) _____, (address) _____, (telephone) _____, to serve as successor agent, with all the same powers as given to the original agent**.** If _____ is unable or unwilling to serve as successor agent, then I appoint (name) _____ _____, (address) _____ _____, (telephone) _____, to serve as successor agent, with all the same powers as given to the original agent.

B. General Powers for Health Care Purposes Granted: I give and grant unto my said agent for health care decisions full power and authority to make health care decisions for me and in my name, including but not limited to the power to consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, do and perform every act necessary and proper to be done in the exercise of any of the foregoing powers as fully as I might or could do if I were then personally able to participate in such health care decisions, and I hereby ratify and confirm all that my said agent shall lawfully do or cause to be done by virtue hereof.

C. Expressly Authorized Actions: In addition to the general power and authority granted above, my agent hereunder shall have the following expressly enumerated

powers; provided, however, that nothing herein shall be deemed to restrict in any way the above general grant of authority:

(1) To have the same access to health care records and information that I could have, including the right to disclose the contents to others and to discuss treatment decisions with health care personnel and others.

(2) To retain and dismiss health care and social service providers, and other support personnel responsible for my care.

(3) To admit or transfer me to or discharge me from (even against medical advice) any health care institution, nursing home, assisted living facility, or other facility or program, within or outside of the State of Missouri.

(4) To nominate one or more persons (including my said agent hereunder) to serve as guardian of my person; in the event a guardian, other than my agent, is appointed by a court for me, however, I hereby direct that my agent appointed herein, and not such guardian, shall continue to make health care decisions for me pursuant to this durable power of attorney.

(5) To take any legal action reasonably necessary to do what I have directed in this instrument.

(6) To give or withhold consent to an autopsy or postmortem examination.

(7) To have the "right of sepulcher," and therefore the right to control the burial of my body.

D. Withdrawing or Withholding Certain Life-Prolonging Procedures: Pursuant to Missouri Revised Statute § 404.820, I hereby confer on my agent the authority to direct a health care provider to withhold or withdraw certain life-prolonging procedures, in accordance with the Advance Health Care Directive that is attached to and made a part of this Durable Power of Attorney for Health Care Decisions.

E. Commencement of Authority: The powers and duties of my agent for health care decisions shall commence if and when I become incapacitated, which shall occur, for purposes of this instrument, when I am unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions concerning my medical care. My incapacity shall be deemed to exist when my attending physician certifies in writing that in his or her opinion I am incapacitated. If my attending physician subsequently certifies in writing that I have regained my capacity, this Durable Power of Attorney for Health Care Decisions shall not be revoked but shall become effective again upon my subsequent incapacity as provided above. Notwithstanding the foregoing, my attending physician who certifies my incapacity need not incorporate the certification into my records, set forth the facts on which the determination of incapacity is based, set forth

the expected duration of my incapacity, or periodically review his or her determination of incapacity unless requested to do so in any such case by my agent designated herein.

F. Duty to Seek Information: In making any decision hereunder, my agent for health care decisions shall seek and consider information concerning my medical diagnosis, my prognosis, and the benefits and burdens of the treatment to me to the extent possible within prevailing medical standards.

G. Reimbursement of Expenses: As I do not wish to financially burden my agent for health care decisions for services hereunder, my agent shall be entitled to reimbursement, out of my assets or out of any trust created by me for my benefit, for the reasonable expenses incurred as a result of acting as my agent hereunder.

H. Revocation of Prior Powers of Attorney for Health Care Decisions: This Durable Power of Attorney for Health Care Decisions revokes any prior durable power of attorney for health care decisions and any other document with similar titles and/or intent regarding health care decisions.

I. General Directives: The directives contained herein are general and have been made after careful consideration. I recognize that I cannot presently foresee all possible situations and evaluate what my response to those situations would be. Therefore, I have granted my agent for health care decisions broad power and authority to make decisions in response to specific situations regarding my health care. I trust the person(s) who may act as my agent and successor attorney(s)-in-fact hereunder, they are familiar with my wishes and beliefs, and I ask my health care providers to look to my agent for health care decisions when making specific decisions regarding my health care.

J. Application of My Advance Health Care Directive: If this Durable Power of Attorney for Health Care Decisions is somehow determined to be ineffective, or if none of my named attorneys-in-fact are able to serve, my Advance Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life prolonging procedures.

K. Revocability of this Instrument: This Advance Health Care Directive and Durable Power of Attorney for Health Care Decisions may be revoked by me at any time, which revocation shall be effective on my communication of such revocation in writing to my agent for health care decisions, or to my attending physician or health care provider, or orally in front of both my agent for health care decisions and attending physician or health care provider.

L. Waiver of Confidentiality Obligations: In order to effectuate the terms of this instrument, I hereby waive any confidentiality obligations under any state or Federal law relating to my incapacity, and I specifically direct that any physician or other health care provider, insurance company, or employer freely transmit and release "Protected Health Information" (as defined in the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 privacy rules) to my agent herein named. My agent shall act,

effective immediately, as my "personal representative" as defined in 45 C.F.R. § 154.502(g), the regulations enacted pursuant to HIPAA, and as hereafter amended, for the purpose of authorizing the complete release of my complete health record as may be necessary in order to obtain for my benefit medical treatment or consultation.

THIS IS A DURABLE POWER OF ATTORNEY TO MAKE HEALTH CARE DECISIONS AND THE AUTHORITY OF MY AGENT TO EXERCISE ALL POWERS ABOVE SHALL BECOME EFFECTIVE IF AND WHEN, AND SHALL NOT BE VOID OR VOIDABLE IF I BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

ANY PERSON RELYING ON THIS ADVANCE HEALTH CARE DIRECTIVE AND POWER OF ATTORNEY MAY RELY ON A PHOTOCOPY OF IT AS IF IT WERE AN ORIGINAL.

IN WITNESS WHEREOF, I have executed this Advance Health Care Directive and Durable Power of Attorney for Health Care Decisions instrument on this _____ day of _____, 20___ in the County of _____, Missouri.

_____

Print Name _____,

Declarant & Principal

REMAINDER OF PAGE LEFT BLANK INTENTIONALLY

Witnesses

The Declarant and Principal, _____, is known to us, is at least eighteen years of age, is of sound mind and voluntarily signed this instrument in our presence.

1. _____

Print Name: _____

Address: _____

_____

Phone: _____

2. _____

Print Name: _____

Address: _____

_____

Phone: _____

STATE OF MISSOURI)
) ss.
COUNTY OF _____)

On this _____ day of _____, 20___, before me, a Notary Public, in and for the State of Missouri, personally appeared _____, Declarant and Principal, to me known to be the person described and who executed the foregoing Advance Health Care Directive and Durable Power of Attorney for Health Care Decisions and acknowledged that she executed the same as her free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid on the day and year first above written.

_____
Notary Public

My commission expires: _____