The Halachic Medical Directive

PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE AND POST-MORTEM DECISIONS

FOR USE IN THE STATE OF NEW HAMPSHIRE

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 February 2022. 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 your name on the first line of the form.** In order for this form to be valid you must be at least 18 years of age.

(b) **In Section 1, print the name, address, and telephone numbers of the person you wish to designate as your *agent*** to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own. Be sure to include all contact information (including cell phone and e-mail) 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 main agent is unable, unwilling, or unavailable to make such decisions.

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

Note: *New Hampshire law allows virtually any competent adult* (i.e., a person who is at least eighteen years of age) *to serve as a health care agent*. Thus, you may appoint as your agent (or alternate agent) your spouse, adult child, parent or other adult relative.

A person may not be an agent while serving in one of the following capacities: 1) Your attending practitioner or a person acting under the direct authority of your attending practitioner, or 2) A person not related to you who is an employee of your health care provider or residential care provider.

(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 Chayim Aruchim as the organization you select, phone number 718-ARUCHIM (718-278-2446).

(d) **On page 4, sign and print your name, address, phone numbers, and the date.** If you are physically unable to sign, this document may be signed by another person who signs your name in your physical presence and at your express direction.

(e) **Your signature must be attested to in one of the following two ways:**

1) **(Page 5) Two or more subscribing witnesses who are present when you sign**. The witnesses shall affirm that you appeared to be of sound mind and free from duress at the time the advance directive was signed and that you affirmed awareness of the nature of the document and signed it freely and voluntarily.

A witness must be a competent person 18 years or older. Neither of the witnesses may, at the time of execution, be: the agent; your spouse or heir at law; a person entitled to any part of your estate upon your death under a will, trust, or other testamentary instrument or deed in existence or by operation of law; attending practitioner; or person acting under the direction or control of the attending practitioner. No more than one witness may be your health or residential care provider or such provider's employee.

2) **(Page 6) A notary public or justice of the peace who is present when you sign**, who shall acknowledge your signature pursuant to the provisions of New Hampshire Revised Statutes Section 456-B.

(f) It is recommended that you keep the original of this form among your valuable papers in a location that is readily accessible in the event of an emergency; and that you **distribute copies to the health care agent (and alternate agent)** you have designated in 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.

(g) 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.

(h) If at any time you wish to revoke this Proxy and Directive, you may do so by: executing a new one; by a written revocation delivered to the agent or to a health care provider or residential care provider expressing your intent to revoke, signed and dated by you; by oral revocation in the presence of 2 or more witnesses, none of whom shall be a person disqualified from acting as a witness under New Hampshire Revised Statutes Section 137-J:14, I(a); or by any other act evidencing a specific intent to revoke the power, such as by burning, tearing, or obliterating the same or causing the same to be done by some other person at your direction and in your physical presence.

To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Proxy and Directive and destroy them. If you do not revoke the Proxy and Directive, New Hampshire law provides that it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Proxy and Directive dies or becomes otherwise incapable of serving in the role you have assigned, you should execute a new Proxy and Directive.

(i) It is recommended that you also complete 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 Proxy and 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.

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PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN THE STATE OF NEW HAMPSHIRE

AN ADVANCE DIRECTIVE IS A LEGAL DOCUMENT. YOU SHOULD KNOW THESE FACTS BEFORE SIGNING IT.

• This form allows you to choose who you want to make decisions about your health care when you cannot make decisions for yourself. This person is called your "agent". You should consider choosing an alternate in case your agent is unable to act.

• Agents must be 18 years old or older. They should be someone you know and trust. They cannot be anyone who is caring for you in a health care or residential care setting.

• This form is an "advance directive" that defines a way to make medical decisions in the future, when you are not able to make decisions for yourself. It is not a medical order (e.g., it is not in and of itself a DNR (do not resuscitate order or (POLST)).

• You will always make your own decisions until your medical practitioner examines you and certifies that you can no longer understand or make a decision for yourself. At that point, your "agent" becomes the person who can make decisions for you. If you get better, you will make your own healthcare decisions again.

• With few exceptions(*), when you are unable to make your own medical decisions, your agent will make them for you, unless you limit your agent's authority in the durable power of attorney form. Your agent can agree to start or stop medical treatment, including near the end of your life. Some people do not want to allow their agent to make some decisions. Examples of what you might write in include: "I do NOT want my agent...

- to ask for or agree to stop life-sustaining treatment (such as breathing machines, medically-administered nutrition and/or hydration (tube feeding), kidney dialysis, other mechanical devices, blood transfusions, and certain drugs)."
- to ask for or to agree to a Do Not Resuscitate Order (DNR order)."
- to agree to treatment even if I object to it in the moment, after I have lost the ability to make health care decisions for myself."

• The law allows your agent to put you in a clinical trial (medical study) or to agree to new or experimental treatment that is meant to benefit you if you have a disease or condition that is immediately life-threatening or if untreated, may cause a serious disability or impairment (for example new treatment for a pandemic infection that is not yet proven). You may change this by writing in the durable power of attorney for health care form:

º "I want my agent to be able to agree to medical studies or experimental treatment in any situation." or
º "I don't want to participate in medical studies or experimental treatment even if the treatment may help me or I will likely die without it."

• Your agent must try to make the best decisions for you, based on what you have said or written in the past. Tell your agent that you have appointed them as your healthcare decision maker. Talk to your agent about your wishes.

• In the "living will" section of the form, you can write down wishes, values, or goals as guidance for your agent, surrogate, and/or medical practitioners in making decisions about your medical treatment.

• You do not need a lawyer to complete this form, but feel free to talk to a lawyer if you have questions about it.

• You must sign this form in the physical presence of 2 witnesses or a notary or justice of the peace for it to be valid. The witnesses cannot be your agent, spouse, heir, or anyone named in your will, trust or who may otherwise receive your property at your death, or your attending medical practitioner or anyone who works

directly under them. Only one witness can be employed by your health or residential care provider.
• Give copies of the completed form to your agent, your medical providers, and your lawyer.

* Exceptions: Your agent may not stop you from eating or drinking as you want. They also cannot agree to voluntary admission to a state institution; voluntary sterilization; withholding life-sustaining treatment if you are pregnant, unless it will severely harm you; or psychosurgery.

I, _____, born on _____, residing at _____, 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 designate and appoint

Agent

Name of Agent:
_____
Address:
_____
Telephone: Home: Work:
_____ _____
Cell: E-mail:
_____ _____

as my health care 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

Alternate Agent

Name of Alternate Agent:
_____
Address:
_____
Telephone: Home: Work:
_____ _____
Cell: E-mail:
_____ _____

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. By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

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 (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.

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: Home: _____ Work: _____

Cell: _____ E-mail: _____

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: Home: _____ Work: _____

Cell: _____ E-mail: _____

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: _____ E-mail: _____

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.

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 alternate agent are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined 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: I direct that all of my protected health information (as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("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. In the event that the authority of my agent has not yet been established, I authorize each of my health care providers to release and disclose all my protected health information and other medical records to the individual nominated hereunder as my agent for the purpose of determining my capacity to make my own health care decisions, including, without limitation, the issuance and release of any written opinion relating to my capacity that such person may have requested.

The foregoing direction and authorization shall supersede any prior agreement that I may have made with any of my health care providers to restrict access to or disclosure of my protected health information or other medical records, and shall expire with respect to any health care provider upon being revoked by me in a writing delivered to such health care provider.

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. 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 in section 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 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 in section 3 above should be followed in determining the requirements of Jewish law and custom.

8. Request to Medical Providers: I have made the decisions set forth in this document, particularly those stating that I want my health care decisions to be made by my health care agent (should I not be capable of making my own decisions) in accordance with Orthodox Jewish law in consultation with an Orthodox rabbi, after a great deal of thought and in view of my very deeply-held religious beliefs. I am aware that there may come a time when I am asked to reconsider these decisions, possibly when I am in a hospital or other institutional setting with serious health issues and my ability to think clearly and articulate my views has been compromised by illness, medication, or physical or emotional pain. If I am no longer capable of making my own decisions then of course I want my health care agent to make health care decisions for me. But if I am still capable of making my own decisions, while I wish to maintain autonomy to do so, I do not want to be subjected to pressure by any health care provider to change the position I have taken in signing this document. I therefore implore all medical providers to please (a) not try to persuade me to vary from the position I have articulated in this document and (b) if you are going to have a discussion with me about my health care decisions, that you only do so with my health care agent (or alternate agent) and if possible my rabbi as well, participating in the discussion, ideally in person or by phone if necessary, and with this document in front of you and read to me as part of that conversation.

9. Duration and Revocation: I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself. 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.

SIGNATURE

I have received, reviewed, and understood the disclosure statement, and I have completed the durable power of attorney for health care consistent with my wishes.

My Signature Signature: _____

Print Name: _____

Date: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell: _____ E-mail: _____

DECLARATION OF WITNESSES

I declare under penalty of perjury that the principal is personally known to me; that the principal signed or acknowledged this durable power of attorney in my presence; that the principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as agent by this document; that I am not a spouse, heir, or anyone named in the principal's will, trust or who may otherwise receive property at the principal's death; or the principal's attending medical practitioner or anyone who works directly under them.

Witnesses

Witness 1:
SIGNATURE
_____
Print Name:
_____
Residing at:
_____
Date:
_____

Witness 2:
SIGNATURE
_____
Print Name:
_____
Residing at:
_____
Date:
_____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION)
I further declare under penalty of perjury that I am not employed by the principal's health or residential care provider.

Signature: _____

Signature: _____

[Alternative to DECLARATION OF WITNESSES:]

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of New Hampshire }
} ss.
County of _____ }

On this_____day of_____, in the year_____, before me,_____ (here insert name of notary public) personally appeared_____(here insert name of principal) personally known to me (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, and appears to be of sound mind and free from duress.

NOTARY SEAL

_____
(Signature of Notary Public)

My commission expires: _____

Emergency Instructions

I, _____ have executed a "Halachic Medical Directive with respect to medical and post-mortem decisions, dated _____." Pursuant to my "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:_____

Cell:_____ E-mail:_____

Alternate Agent:_____

Phone: _____

Cell:_____ E-mail:_____

Rabbi:_____

Phone: _____

Cell: _____ E-mail:_____

Organization:_____

Phone: _____ E-mail:_____