

# *The Halachic Medical Directive*

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

### *FOR USE IN THE STATE OF VERMONT*

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 March 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.

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### 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: *Vermont law allows virtually any competent adult* (an adult means 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.

Your health care provider cannot be your agent. If you live in a residential care facility, health care facility, or correctional facility when executing this form, your agent cannot be an employee, owner, agent, or contractor of that facility *unless* he or she is related to you by blood, marriage, civil union, or adoption.

(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 or mark the health care power of attorney, another individual may execute the form in your presence at your express direction that you intended to adopt the power of attorney at that time.

(e) **On page 5, this document must be notarized or witnessed in writing by at least two adults** who affirm that they were present when you dated and signed or marked the health care power of attorney (except when you are physically unable to do so, see (d) above), and that you appeared to be of sound mind and free from duress at the time of execution of the health care power of attorney.

The witnesses shall not be any of the following: 1) the agent appointed by this form 2) your spouse, parent, adult sibling, adult child, or adult grandchild.

(f) **On page 6, if you are being admitted to or are a resident of a nursing home or residential care facility, the nature and effect of this advance directive must be explained to you by one of the following people:**

- (1) an ombudsman;
- (2) a recognized member of the clergy;
- (3) an attorney licensed to practice in this State;
- (4) a Probate Division of the Superior Court designee;
- (5) an individual designated by a hospital pursuant to subsection 9709(d) of this title;
- (6) a mental health patient representative;
- (7) an individual who is volunteering at the nursing home or residential care facility without compensation and has received appropriate training regarding the explanation of advance directives; or
- (8) a clinician, as long as the clinician is not employed by the nursing home or residential care facility at the time of the explanation.

If you are being admitted to or are a patient at a hospital, the nature and effect of this advance directive must be explained to you by one of the following people:

- (1) an ombudsman;
- (2) a recognized member of the clergy;
- (3) an attorney licensed to practice in Vermont;
- (4) a Probate Division of the Superior Court Designee;
- (5) an individual designated by the hospital pursuant to 18 V.S.A. § 9709(d);
- (6) a mental health patient representative.

If applicable, an appropriate individual must explain the nature and effect of this advance directive to you and sign **on page 6**.

(g) 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.**

(h) 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.

(i) If at any time you wish to revoke this Proxy and Directive, you may do so by executing a new one; signing a statement suspending or revoking all or part of the advance directive; personally informing your clinician your intent to revoke; or by burning, tearing, or obliterating this advance directive either yourself or by another person in your presence at your express direction. 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, Vermont 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.

(j) 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.

(k) 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 VERMONT***

I, \_\_\_\_\_, hereby declare as follows:

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

*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 and that I am not the principal's spouse, parent, adult sibling, adult child, or adult grandchild.

*Witnesses*

Witness 1:  
SIGNATURE

\_\_\_\_\_

Print Name:

\_\_\_\_\_

Date:

\_\_\_\_\_

Witness 2:  
SIGNATURE

\_\_\_\_\_

Print Name:

\_\_\_\_\_

Date:

\_\_\_\_\_



**DECLARATION FOR NURSING HOME OR RESIDENTIAL CARE FACILITY**

I declare that I have explained the nature and effect of an advance directive to the principal because the principal is being admitted to or is a resident of a nursing home as defined in 33 V.S.A. § 7102 or a residential care facility. I am one or more of the following: (1) an ombudsman; (2) a recognized member of the clergy; (3) an attorney licensed to practice in this State; (4) a Probate Division of the Superior Court designee; (5) an individual designated by a hospital pursuant to subsection 9709(d) of this title; (6) a mental health patient representative; (7) an individual who is volunteering at the nursing home or residential care facility without compensation and has received appropriate training regarding the explanation of advance directives; or (8) a clinician, as long as the clinician is not employed by the nursing home or residential care facility at the time of the explanation.

SIGNATURE

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date:  
\_\_\_\_\_

**DECLARATION FOR HOSPITAL**

I declare that I have explained the nature and effect of an advance directive to the principal because the principal is being admitted to or is a patient in a hospital. I am one or more of the following: (1) an ombudsman; (2) a recognized member of the clergy; (3) an attorney licensed to practice in Vermont; (4) a Probate Division of the Superior Court Designee; (5) an individual designated by the hospital pursuant to 18 V.S.A. § 9709(d); (6) a mental health patient representative.

SIGNATURE

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date:  
\_\_\_\_\_

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### 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

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**EMERGENCY INSTRUCTIONS**

Agent: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Alternate Agent: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Rabbi: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_