The Halachic Medical Directive

HEALTH CARE POWER OF ATTORNEY

FOR USE IN PENNSYLVANIA

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 May 2009. 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.**

(b) **In section 1, print the name, address, and day, evening and cell/pager 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 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 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: This form is effective only if you and your agents are competent adults (an adult is a person 18 years of age or older, or a person who has graduated from high school, has married, or is an emancipated minor).

Note: You may not appoint your attending physician or other health care provider (or an owner, operator or employee of such health care provider).

(c) **In section 2, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you ask 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.

(d) **At the end of the form, sign and print your name, address, phone numbers, and the date before two witnesses.** If you are not physically able to do these things, Pennsylvania law allows another person to sign and date the form on your behalf, as long as he or she does so *at your direction, in your presence,* and *in the presence of the two witnesses.*

The two witnesses must be competent adults. *Neither of them should be the person you have appointed as your health care agent (or alternate agent).* They may, however, be your relatives.

(e) **In the DECLARATION OF WITNESSES section beneath your signature, two witnesses should sign their names and insert their addresses beneath their signature.** These witnesses must be 18 years old or older. Neither of them may be the person who has signed the declaration on your behalf and at your direction.

(f) It is recommended that you keep the original of this form among your valuable papers; and that you **distribute copies to the agent (and alternate agent)** you have designated in section 1, **to the Rabbi and institution/organization** you have designated in section 2, as well as to **your doctors, 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 PAdirective@agudathisrael.org or call our office (212-797-9000).

(g) **If at any time you wish to revoke this Health Care Power of Attorney, you may do so by executing a new one or by a writing revoking this instrument (which is signed and witnessed using the same rules as for this document); or by personally informing the attending physician, health care provider or agent that the document is revoked.** By law, an appointment of your spouse as your agent is automatically revoked upon divorce or legal separation, unless you specify otherwise.

If you do not revoke the Health Care Power of Attorney, Pennsylvania law provides that it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Power of Attorney dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new Health Care Power of Attorney.

(h) It is recommended that you also complete the **Emergency Instructions**, 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 document 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.

PENNSYLVANIA HEALTH CARE POWER OF ATTORNEY

I, ________________________, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitments, as indicated below.

1. Appointment of Agent:

I wish to designate another person as my agent to make medical treatment decisions for me and to authorize medical and surgical procedures if I should be incompetent to make or communicate health care decisions for myself, and/or in a terminal condition, and/or in a state of permanent unconsciousness.

Agent

Name of Agent: ____

Address: ____

____

Telephone: Day: ____________________ Evening: ____________________

Cell/Pager: ____________________

Name and address of substitute agent (if the agent designated above is unable to serve):

Alternate Agent

Name of Alternate Agent: ____

Address:____

____

Telephone: Day: ____________________ Evening: ____________________

Cell/Pager: ____________________

2. Additional Instructions:

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 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, and I ask my agent to follow the guidance of, the following Orthodox Rabbi:

Rabbi Name of Rabbi: ____

Address: ____

____

Telephone: Day: ____________________ Evening: ____________________

Cell/Pager: ____________________

If the Orthodox Rabbi named 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, 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 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 the above section named "Ascertaining the Requirements of Jewish Law" 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. In addition, each individual nominated hereunder as my agent is a person involved in my care as set forth under HIPAA and I request that my health care providers release and disclose to such individual upon request such of my protected health information and other medical records as may be necessary for my proper care, as permitted under HIPAA, including without limitation such records and information (and the issuance and release of any written opinion requested by such individual) relating to my inability to make my own health care decisions for purposes of section 1 above.

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 further direct that my agent be responsible for 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 the section above named "Ascertaining the Requirements of Jewish Law", 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 declaration or proxy, or if the persons designated in section 1 above as my surrogate and alternate surrogate 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.

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: ____

____

Telephone: Day: ______________________ Evening: ______________________

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

WITNESS 1:

Signature: ____

Print Name: ____

Residing at: ____

____

WITNESS 2 ____

Signature : ____

Print Name : ____

Residing at: ____