

# *The Halachic Medical Directive*

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

### **FOR USE IN WISCONSIN**

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.

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### **INSTRUCTIONS**

(a) **Please print your name on the first line of the form.**

(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 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*), you may wish to advise your agents of such arrangements.

Note: *Wisconsin law allows virtually any competent adult* (an adult is a person 18 years of age or older) *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. You may not, however, appoint as your health care agent any person who is your health care provider, an employee of your health care provider or an employee of a health care facility in which you are a patient or reside, or a spouse of any of those providers or employees, unless the health care provider, employee or spouse of the provider or employee is a relative of yours.

(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.

(d) **In Section 5, place your initials in the space provided to indicate whether you would like to authorize your health care agent to make decisions on your behalf if you are pregnant when this document takes effect.** Should you so authorize your agent, he/she will remain obligated to follow the religious instruction of the Rabbi that you designate on this form. If you do not authorize your agent to make decisions on your behalf and you are pregnant when this document takes effect, your health care decisions will be made by your physician in accordance with the laws of the State of Wisconsin.

(e) **In Section 9, sign and print your name, address, phone numbers, and the date.** If you are not physically able to do these things, Wisconsin law allows another person to sign and date the form on your behalf, as long as he or she is over the age of 18 years and does so *at your direction, in your presence, and in the presence of two adult witnesses.*

(f) **In the DECLARATION OF WITNESSES Section, two witnesses should sign their names and insert their addresses beneath your signature.** Each witness must be over the age of 18 years. *Neither witness may be the person you have appointed as your health care agent (or alternate agent) or related to you by blood, marriage or adoption. In addition, neither witness may have knowledge that he or she is entitled to or has a claim on any portion of your estate, may be directly financially responsible for your health care, or may be a health care provider who is serving you at the time of execution, an employee (other than a chaplain or a social worker) of the health care provider or an employee (other than a chaplain or a social worker) of an inpatient health care facility in which you are a patient.*

(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. If you wish, you may file this form with the register in probate of your county for safekeeping. The register will charge a fee for this service. 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 [WIdirective@agudathisrael.org](mailto:WIdirective@agudathisrael.org) or call our office (212-797-9000).

(h) This Power of Attorney and Directive takes effect only upon a finding of incapacity by two physicians, or one physician and one licensed psychologist, who personally examine you and sign a statement specifying that you are incapable. Neither of the individuals who make a finding of incapacity may be a relative of yours or have knowledge that he or she is entitled to or has a claim on any portion of your estate. When such a statement is made, a copy must be appended to the Power of Attorney and Directive.

(i) If at any time you wish to revoke this Power of Attorney and Directive, you may do so by executing a new one; or by canceling, defacing, obliterating, burning, tearing or otherwise destroying it or by directing another in your presence to so destroy it. You may also revoke it by executing a written statement,

that you sign and date, expressing your intent to revoke your Power of Attorney and Directive, or you may verbally express your intent to revoke it in the presence of two witnesses. To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Power of Attorney and Directive and destroy them.

If you do not revoke the Power of Attorney and Directive, Wisconsin law provides that it remains in effect indefinitely. However, if one of the individuals that you name as your agent in this document is your spouse, the Power of Attorney is automatically revoked and the instrument becomes invalid in the event of divorce. Obviously, if any of the persons whose names you have inserted in the Power of Attorney and Directive dies or otherwise becomes incapable of serving in the role you have assigned, it would be wise to execute a new Power of Attorney and Directive.

(j) It is recommended that you also complete the **Emergency Instructions Card**, 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 Power of Attorney 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.

<p>These instructions are not part of the Halachic Medical Directive and need not be kept attached to the executed document.</p>
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***POWER OF ATTORNEY AND DIRECTIVE  
WITH RESPECT TO HEALTH CARE DECISIONS  
AND POST-MORTEM DECISIONS  
FOR USE IN WISCONSIN***

NOTICE TO PERSON MAKING THIS DOCUMENT:

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A

COPY. IF YOUR AGENT IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR DOCUMENT OF GIFT THAT YOU MAY HAVE MADE. YOU MAKE REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THAT ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

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 appoint:

<b>Agent</b>	Name of Agent:	_____
	Address:	_____
	Telephone: Day:	_____
	Evening:	_____
	Cell Phone:	_____
	Pager/beeper:	_____

as my health care agent to make any and all health care decisions for me, including placing me in a nursing home or a community-based residential facility, 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:

<b>Alternate Agent</b>	Name of Alternate Agent:	_____
	Address:	_____
	Telephone: Day:	_____
	Evening:	_____
	Cell Phone:	_____
	Pager/beeper:	_____

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.

**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: Day: \_\_\_\_\_ Evening: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Pager/beeper: \_\_\_\_\_

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: \_\_\_\_\_ Pager/beeper: \_\_\_\_\_

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.

**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:** 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.

**6. For Pregnant Women:** If I have placed my initials in the space provided beside the word “Yes” below, subject to following the directions contained in sections 2 and 3 of this document, my health care agent may make health care decisions on my behalf, even if my agent knows that I am pregnant. If I have placed my initials in the space provided beside the word “No” below, my health care agent may not make health care decisions for me if my health care agent knows that I am pregnant.

Authority to make health care decisions if I am pregnant: \_\_\_\_\_ YES      \_\_\_\_\_ NO

**7. 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 paragraph 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

**8. Incontrovertible Evidence of My Wishes:** If, for any reason, this document is deemed not legally effective as a power of attorney for health care, 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.

**9. Duration and Revocation:** It is my understanding and intention that unless I revoke this power of attorney for health care, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a revocation of any prior power of attorney for health care, directive or other similar document I may have executed prior to today's date.

**My Signature**      Signature: \_\_\_\_\_

(If you are not physically capable of signing, please ask another person who is over the age of 18 to sign your name on your behalf.)

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

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

Address: \_\_\_\_\_

### DECLARATION OF WITNESSES

I, on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_, declare that the person who signed (or asked another to sign) this document is personally known to me and appears to be of sound mind and acting voluntarily and free from duress. He/She signed (or asked another to sign for him/her) this document in my presence (and that person signed in my presence). I am not the person appointed as agent or alternate agent by this document. I am not related to the principal by blood, marriage, or adoption, nor do I have knowledge that I am entitled to, or have a claim on any portion of the principal's estate. I am not directly financially responsible for the principal's health care. I am not an individual who is a health care provider who is serving the principal at the time of execution, an employee, other than the chaplain or a social worker, of the health care provider or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the principal is a patient. I am over the age of 18.

**Witnesses**      WITNESS 1

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Residing at: \_\_\_\_\_

WITNESS 2:

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Residing at: \_\_\_\_\_