



Union for Traditional Judaism

Please attach your Living Will to this document.

POWER OF ATTORNEY FOR HEALTH CARE

1. I, _____ hereby appoint:

Address: _____

Home Telephone () _____ Work Telephone () _____

as my attorney-in-fact (or Agent) to make health and personal care decisions for me as authorized in this document.

2. By this document, I intend to create a durable power of attorney effective upon, and only during, any period of incapacity in which, in the opinion of my Agent and attending physician, I am unable to make or communicate a choice regarding a particular health care decision.

3. I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or in my living will or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be my best interests. My Agent's authority to interpret my desires is limited only by statements in this document and my Living Will (hereunto attached). Accordingly, only after consulting with a rabbi versed in Jewish law and Jewish medical ethics, unless specifically limited by Section 4 below, my Agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, and cardiopulmonary resuscitation;

B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;

D. To contract on my behalf for any health care related service or facility on my behalf, without

my Agent incurring personal financial liability for such contracts;

E. To hire and fire medical, social service, and other support personnel responsible for my care;

F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain;

G. To allow the use of my organs for, immediate life saving purposes and to direct the disposition of my remains, to the extent permitted by Jewish law;

H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider, signing any document relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for the failure to comply.

4. Regarding all life sustaining treatment at a time when my condition is concluded to be irreversible, I want my Agent to make a decision only after consulting with a traditional rabbi versed in Jewish law and Jewish medical ethics. My intent is to be certain that a decision concerning the extension of my life be made in consonance with traditional Jewish law.

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that I do not intend to include these procedures among the "life sustaining procedures" that may be withheld or withdrawn under the conditions given above.

5. If any Agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if any Agent is my spouse) be legally separated or divorced from me, I name the following (each to act alone and successively, in the order named) as successors to my Agent.

A. First Alternate Agent: _____

Address: _____

Telephone: () _____

B. Second Alternate Agent: _____

Address: _____

Telephone: () _____

6. No person who relies in good faith upon any representations by my Agent or Successor shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

7. If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor), named above. .

8. (a) I revoke any prior power of attorney for health care.

(b) This power of attorney is intended to be valid in any jurisdiction in which it is presented.

(c) My Agent shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.

(d) The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. ,

I sign my name to this Health Care Power of Attorney on this _____ day of _____, 20____.

My current home address is: _____

Signature: _____

Name: _____

I declare that the person who signed or acknowledged this document is personally known to me, that he/she signed or acknowledged this durable power of attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as agent by this document, nor am I the patient's health care provider or an employee of the patient's health care provider. I further declare that I am not related to the principal by blood, marriage or adoption, and, to the best of my knowledge, I am not a creditor of the principal nor entitled to any part of his/her estate under a will now existing or by operation of law.

Witness

Signature: _____ Date: _____

Print name: _____ Telephone: _____

Residence Address: _____

Witness

Signature: _____ Date: _____

Print name: _____ Telephone: _____

Residence Address: _____

STATE OF _____ COUNTY OF _____

On this _____ day of _____ 20____, the said _____ known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed that same for the purposes stated therein.

My Commission Expires:

NOTARY PUBLIC