

# **NEW JERSEY**

## **Advance Directive**

### **Planning for Important Healthcare Decisions**

Courtesy of CaringInfo  
[www.caringinfo.org](http://www.caringinfo.org)

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **ACTION STEPS**

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

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5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## **INTRODUCTION TO YOUR NEW JERSEY ADVANCE HEALTH CARE DIRECTIVE**

This packet contains a legal document, a **New Jersey Advance Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

**Part I** is the **New Jersey Proxy Declaration**. This part lets you name an adult, called your health care representative, or representative, to make decisions about your health care—including decisions about life-sustaining treatments—if you can no longer speak for yourself.

**Part II** is a **New Jersey Instruction Declaration**, which is your state's living will. Part II lets you state your wishes regarding health care decisions in the event that you can no longer make your own.

**Part III** contains the signature and witnessing provisions so that your document will be effective.

You may fill out Part I, Part II, or both, depending on your advance planning needs. **You must complete Part III.**

### **How do I make my New Jersey Advance Health Care Directive legal?**

You must sign and date your document, or direct another to sign and date it:

1. in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative;

**OR**

2. before a notary public, an attorney at law, or another person authorized to administer oaths.

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You **cannot** appoint an operator, administrator, or employee of your treating healthcare institution, unless he or she is related to you by blood, marriage, domestic partnership, or adoption. However, you can appoint a physician so long as he or she is not serving as your attending physician at the same time.

You can appoint a second person as your alternate agent. An alternate agent will step in if the person you name as agent is unable, unwilling, or unavailable to act for you.

### **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

### **When does my agent's authority become effective?**

Your advance directive goes into effect when your doctor and one other doctor determine in writing that you are no longer able to understand and appreciate the nature and consequences of your healthcare decisions and you are no longer able to reach an informed healthcare decision.

### **Agent Limitations**

If you are female, you may include instructions specific to your pregnancy in the event that you are pregnant when your Advance Directive goes into effect; however, your agent will be bound by the current laws of New Jersey as they regard pregnancy and termination of pregnancies.

### **What if I change my mind?**

You may revoke your Advance Directive, or any part of it, at any time by:

- Announcing your revocation either orally or in writing to your healthcare representative, your doctor or other healthcare provider, or a reliable witness,
- Performing any other act that demonstrates your intent to revoke the document, or
- Executing a subsequent Advance Directive.

If you designate your spouse as your representative, his or her authority is automatically revoked upon divorce or legal separation, unless you specify otherwise in the "further instructions" section of the Advance Directive. If you designate your domestic partner, his or her authority is automatically revoked upon termination of your domestic partnership, unless otherwise specified in the "further instructions" section of the Advance Directive.

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

## **What other important facts should I know?**

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form **MUST** be signed by a healthcare provider and **MUST** be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

**NEW JERSEY ADVANCE DIRECTIVE – PAGE 1 OF 10**

**PART I**

PRINT YOUR NAME

PRINT THE NAME,  
ADDRESS AND  
HOME AND WORK  
TELEPHONE  
NUMBERS OF YOUR  
HEALTH CARE  
REPRESENTATIVE

PRINT THE NAME,  
ADDRESS, AND  
TELEPHONE  
NUMBER OF YOUR  
FIRST ALTERNATE  
HEALTH CARE  
REPRESENTATIVE

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**PART I: PROXY DIRECTIVE**

I, \_\_\_\_\_, hereby appoint:  
(your name)

\_\_\_\_\_  
(name of health care representative)

\_\_\_\_\_  
(address of health care representative)

\_\_\_\_\_ (home phone number)

\_\_\_\_\_ (work phone number)

to be my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining treatment. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear or if a situation arises that I did not anticipate, my health care representative is authorized to make decisions in my best interests.

If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the following order of priority:

1. Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Telephone \_\_\_\_\_

**NEW JERSEY ADVANCE DIRECTIVE - PAGE 2 OF 10**

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PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBER OF  
YOUR SECOND  
ALTERNATE  
HEALTH CARE  
REPRESENTATIVE

2. Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Telephone \_\_\_\_\_

I direct that my health care representative comply with the following instructions and/or limitations (optional):

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(use additional pages if necessary)

I direct that my health care representative comply with the following instructions in the event that I am pregnant when this Directive becomes effective (optional):

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(use additional pages if necessary)

ADD ADDITIONAL  
INSTRUCTIONS,  
IF ANY

ADD  
INSTRUCTIONS, IF  
ANY, TO BE  
FOLLOWED IN THE  
EVENT YOU  
ARE PREGNANT

PART II

**PART II. INSTRUCTION DIRECTIVE**

In Part II, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your health care representative, doctor and family members or others who may become responsible for your care.

In the sections below, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use the "Further Instructions" section below, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. **Please familiarize yourself with all sections of Part II before completing your directive.**

**General Instructions.**

To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care.

**Initial ONE of the following two statements with which you agree:**

INITIAL ONLY ONE

1. \_\_\_\_\_ I direct that all medically appropriate measures be provided to sustain my life regardless of my physical or mental condition.

2. \_\_\_\_\_ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

IF YOU INITIAL  
STATEMENT 2, YOU  
MUST SPECIFY  
WHEN YOU WOULD  
LIKE TO FOREGO  
LIFE-SUSTAINING  
MEASURES ON THE  
FOLLOWING PAGES

**If you have initialed statement 2, on the following page please initial each of the statements (a, b, c) with which you agree:**

## NEW JERSEY ADVANCE DIRECTIVE - PAGE 4 OF 10

INITIAL EACH  
LETTERED  
STATEMENT (A, B,  
AND/OR C) THAT  
REPRESENTS WHEN  
YOU WOULD LIKE  
TO FOREGO LIFE-  
SUSTAINING  
MEASURES

IF YOU INITIALED  
STATEMENT A,  
INDICATE WHAT  
YOU CONSIDER TO  
BE A TERMINAL  
CONDITION THAT  
WILL JUSTIFY THE  
WITHHOLDING OR  
DISCONTINUING OF  
LIFE-SUSTAINING  
MEASURES

**a.** \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and relieve pain. To me, terminal condition means that my physicians have determined that:

\_\_\_\_\_ I will die within a few days, or

\_\_\_\_\_ I will die within a few weeks, or

\_\_\_\_\_ I have a life expectancy of approximately \_\_\_\_\_ or less (enter 6 months or 1 year)

**b.** \_\_\_\_\_ If there should come a time when I become permanently unconscious, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate care necessary to provide for my personal hygiene and dignity.

**c.** \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental or physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations, which would provide further guidance to those



IF YOU INITIALED  
STATEMENT C,  
ABOVE, YOU MAY  
LIST CONDITIONS  
THAT YOU FIND  
UNACCEPTABLE  
AND WOULD  
JUSTIFY THE  
WITHHOLDING OR  
DISCONTINUING OF  
LIFE-SUSTAINING  
MEASURES

INITIAL YOUR  
PREFERENCE  
REGARDING  
ARTIFICIALLY  
PROVIDED FLUIDS  
AND NUTRITION  
(FOOD AND DRINK)

INITIAL YOUR  
PREFERENCE  
REGARDING CPR

YOU MAY ADD  
FURTHER  
INSTRUCTIONS  
REGARDING  
ARTIFICIALLY  
PROVIDED FLUIDS  
AND NUTRITION OR  
CPR HERE

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Revised.

who may become responsible for your care. If necessary, you may attach a separate statement to this document or provide your wishes in the "Further Instructions" section, below.)

Examples of conditions that I find unacceptable are:

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**Specific Instructions: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).**

On page 4, above, you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures—artificially provided fluids and nutrition and cardiopulmonary resuscitation.

In the space provided, initial the phrase with which you agree:

1. In the circumstances I initialed on page 4, I also direct that artificially provided fluids and nutrition, such as feeding tube or intravenous infusion, \_\_\_\_\_be withheld or withdrawn and that I be \_\_\_\_\_allowed to die, or \_\_\_\_\_be provided to the extent medically appropriate.

2. In the circumstances I initialed on page 4, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR) \_\_\_\_\_not be provided and that I be allowed to die, or

medically \_\_\_\_\_be provided to preserve my life, unless inappropriate or futile.

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

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INITIAL HERE IF  
YOU HAVE AN  
OBJECTION TO  
NEW JERSEY'S  
BRAIN DEATH  
DEFINITION

ORGAN DONATION  
(OPTIONAL)

INITIAL THE  
STATEMENT THAT  
BEST REFLECTS  
YOUR WISHES

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**BRAIN DEATH:**

The State of New Jersey has determined that an individual may be declared legally dead when there has been an irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death). However, individuals who do not accept this definition of brain death because of their personal religious beliefs may request that it not be applied in determining their death.

Initial the following statement only if it applies to you:

\_\_\_\_ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared only when my heartbeat and breathing have irreversibly stopped.

**ORGAN DONATION (OPTIONAL)**

(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues, and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)

\_\_\_\_ I do not want to make an organ or tissue donation and I do not want my representative or family to do so.

OR

\_\_\_\_ Upon my death, I wish to donate:

\_\_\_\_ My body for anatomical study if needed.

\_\_\_\_ Any needed organs, tissues, or eyes.

\_\_\_\_ Only the following organs, tissues, or eyes:

\_\_\_\_\_  
\_\_\_\_\_

I authorize the use of my organs, tissues, or eyes:

\_\_\_\_ For transplantation

\_\_\_\_ For therapy

\_\_\_\_ For research

\_\_\_\_ For medical education

\_\_\_\_ For any purpose authorized by law.

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[illegible]

**PART III**

USE ALTERNATIVE  
NO. 1 IF YOU PLAN  
TO SIGN BEFORE  
WITNESSES (P. 9)

USE ALTERNATIVE  
NO. 2 IF YOU PLAN  
TO HAVE YOUR  
SIGNATURE  
NOTARIZED (P. 10)

**PART III: EXECUTION**

This advance directive will not be valid unless it is EITHER:

Signed in the presence of two witnesses who must be at least 18 years of age. These witnesses must also sign the document to show that they believe you to be of sound mind, that you voluntarily signed the document, and that they are not your appointed health care representative or alternate health care representative (use Alternative No. 1 if you plan to sign before witnesses);

**OR**

Signed before a notary public, an attorney at law, or another person authorized to administer oaths (use Alternative No. 2 if you plan to have your signature notarized).

**Alternative No. 1.**

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

Signature \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence and he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative or alternate health care representative.

1. Witness \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

2. Witness \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

SIGN AND DATE  
YOUR  
DOCUMENT AND  
PRINT YOUR  
ADDRESS

YOUR WITNESSES  
MUST PRINT THEIR  
NAMES AND  
ADDRESSES AND  
SIGN AND DATE  
HERE

**Alternative No. 2.**

By writing this advance directive, I inform those who may become responsible for my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative(s) and my representative(s) has/have willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive and my wishes. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

Signature \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Notary, Attorney at Law, or other person authorized to administer oaths

On \_\_\_\_\_, before me came  
(date)

\_\_\_\_\_  
(name of declarant)

whom I know to be such person, and the declarant did then and there execute this declaration.

Sworn before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of: (check one)

\_\_\_\_ Notary Public

\_\_\_\_ Attorney at Law

SIGN AND DATE  
YOUR  
DOCUMENT AND  
PRINT YOUR  
ADDRESS

A NOTARY  
PUBLIC OR  
ATTORNEY AT  
LAW SHOULD  
COMPLETE THIS  
SECTION