Always talk to your doctor about your wishes. This form allows you to put your wishes in writing. Written instructions should be followed by your doctor when you cannot speak for yourself.

ABOUT THIS FORM

This is a suggested form, you may use any form of your choice

- You may cross out or add to any of the words in this form. Please initial any changes.
- Give a copy to your proxy and alternate proxy and to your physician.
- Keep the original with your other important papers, but not in a safe deposit box or other place where family members cannot get to it.
- **Bring a copy (or the original) any time you are admitted to the hospital.**

IF YOU HAVE ANY QUESTIONS THAT YOUR DOCTOR CANNOT ANSWER:

973-972-5842 -- Social Work Services

973-972-7251 -- Ethics and Bereavement

LIVING WILL AND HEALTH CARE PROXY

For _____

If I cannot make or communicate decisions about my medical care, those around me should care for me according to the following instructions:

I **do not** want medical treatment (including feeding and water by tube) that will keep me alive if:

- I am unconscious and there is no reasonable chance that I will ever be conscious again, **or**
- I am near death with no reasonable chance of recovery, **or**
- I have an incurable and irreversible illness and the burdens of continued life with life sustaining treatment become greater than the benefits I experience.

I **do** want medicine and other care to make me more comfortable and to take care of pain and suffering. I understand that pain medicines may dull consciousness and indirectly shorten my life.

Optional special instructions :

I know that the above instructions are general and will have to be interpreted. I also know that other decisions about my care may have to be made. Therefore, I am appointing a trusted person who knows me well to decide for me in accordance with my previously expressed wishes.

This person is called a health care representative or proxy and is authorized to make any and all health care decisions for me if I cannot make them myself. This proxy becomes effective when I become incapable of making or communicating decisions about my case.

I appoint _____

Who lives at _____

Phone number ( ) _____

My Advance Directive And Health Care Proxy

If my first choice health care proxy cannot or decides not to act for me, I appoint as my second choice:

I appoint _____

Who lives at _____

Phone number ( ) _____

Signed this _____ ***Day of*** _____

Signiture _____

Address _____

_____

Witness Signature***** _____ Witness Signature* _____

Witness Name _____ Witness Name _____

Witness Address _____ Witness Address _____

_____ _____

_____ _____

****A witness may be any competent adult other than a person named as a health care representative or alternate in this document.***