
The Halachic Living Will

DURABLE POWER OF ATTORNEY FOR HEALTH CARE FOR USE IN GEORGIA

The “Halachic Living Will” 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 Living Will has been approved by attorneys for use in your state as of July, 2005. 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. You must be an individual 18 years of age or older who is of sound mind at the time you execute this document.

INSTRUCTIONS

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

(b) **In section 1, print the name, address, and day and evening 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..

You may also insert the name, address, and telephone numbers of a successor 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 successor 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: *Georgia law allows virtually any competent adult* (an adult is a person 18 years of age or older) *to serve as an agent*. Thus, you may appoint as your agent or successor agent your spouse, adult child, parent or other adult relative. You may also appoint a non-relative to serve as your agent (or successor agent). However, you may not appoint as your agent a health care provider who may be directly or indirectly involved in rendering health care to you under this Durable Power of Attorney for Health Care.

(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 8, sign and print your name, address, phone numbers, and the date before two witnesses.** If you are not physically able to do these things, Georgia 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 (18 years or older). *Neither of them should be the person you have appointed as your agent or successor agent.* They may, however, be your relatives.

(e) **In the DECLARATION OF WITNESSES section beneath your signature, the date should be inserted and the two witnesses should sign their names and insert their addresses beneath their signature.**

(f) **IF YOU ARE A PATIENT IN A HOSPITAL OR SKILLED NURSING FACILITY, the Durable Power of Attorney for Health Care must also be witnessed by your attending physician, who should date and sign the ATTENDING PHYSICIAN ATTESTATION below the Declaration of Witnesses section.**

(g) It is recommended that you keep the original of this form among your valuable papers; and that you **distribute copies to the agent (and successor 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.

(h) **If at any time you wish to revoke this Durable Power of Attorney for Health Care, you may do so by destroying it, by a written revocation which is signed and dated by you or by someone else at your direction, by an oral or other expression of your intent to revoke it before a competent witness who confirms such expression in a dated and signed writing within 30 days of your expression, or by executing a new copy of this form.** By law, your marriage after the execution of this Durable Power of Attorney for Health Care automatically revokes any designation of an agent other than a designation of your spouse. Also, an appointment of your spouse as your agent is automatically revoked upon divorce or dissolution of your marriage.

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

(i) It is recommended that you also complete the **Emergency Instructions Card** contained in the Halachic Living Will brochure and carry it with you in your wallet or purse.

(j) If, upon consultation with your rabbi, you would like to add to this standardized Durable Power of Attorney for Health Care 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 Living Will and need not be kept attached to the executed document.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
FOR USE IN GEORGIA

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

Agent Name of Agent: _____
Address: _____
Telephone: Day: _____ Evening: _____

as my agent (“agent”) to make any and all health care decisions for me, 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

Successor Agent Name of Successor Agent: _____
Address: _____
Telephone: Day: _____ Evening: _____

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 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: _____

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, 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 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 successor 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. 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.

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.

7. Incontrovertible Evidence of My Wishes: If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated in section 1 above as my agent and successor 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.

8. Duration and Revocation: It is my understanding and intention that unless I revoke this proxy and directive, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a revocation of any prior health care proxy, 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 to sign your name on your behalf.)

Print Name: _____

Date: _____

Address: _____

Telephone: Day: _____

Evening: _____

DECLARATION OF WITNESSES

I, being over 18 years of age, 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 willingly 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) and in the presence of the other witness.

Witnesses Witness 1: _____

Residing at: _____

Witness 2: _____

Residing at: _____

ONLY IF YOU ARE SIGNING THIS DOCUMENT IN A HOSPITAL OR A SKILLED NURSING FACILITY, YOUR ATTENDING PHYSICIAN MUST SIGN BELOW.

ATTENDING PHYSICIAN ATTESTATION

I, on this _____ day of _____, 200__, hereby witness this Durable Power of Attorney for Health Care and attest that I believe the person who signed (or asked another to sign) this document to be of sound mind and to have made this Durable Power of Attorney for Health Care willingly and voluntarily.

Attending Physician Signature: _____

Residing at: _____