Legal Forms & Services

FirstName LastName

NEW JERSEY
HEALTH CARE DIRECTIVE
& LIVING WILL

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive & Living Will in New Jersey
After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only
1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Option 2: Notary Only
1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives and living wills, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive and living will. Review your state's laws on witness requirements for health care directives and living wills.

HEALTH CARE DIRECTIVE & LIVING WILL

FOR

FirstName LastName

This document includes the following:

Instruction directive to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

Proxy directive designating a health care representative to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care representative should act in my best interest.

PART ONE: INSTRUCTION DIRECTIVE

I, FirstName LastName, a competent adult, voluntarily declare the following in the event I am unable to make my own health care decisions.

TERMINAL CONDITION. If I am diagnosed as having an irreversibly fatal illness, disease or condition:

_____☑ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

PERMANENTLY UNCONSCIOUS. If I am diagnosed as being permanently unconscious, including in a persistent vegetative state or irreversible coma:

_____☑ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

SERIOUS IRREVERSIBLE ILLNESS. If I have a serious irreversible illness or condition where the likely risks and burdens associated with the medical intervention to be withheld or withdrawn may reasonably be judged to outweigh the likely benefits from such intervention, or imposition of the medical intervention would be inhumane:

_____☑ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

ADDITIONAL INSTRUCTIONS.

I do not wish to leave additional instructions at this time.

AFTER MY DEATH-ANATOMICAL GIFTS.

_____☑ I WANT to donate my organs and parts.

PART TWO: PROXY DIRECTIVE

I, FirstName LastName, being an adult of sound mind, instruct the following pursuant to the laws of New Jersey.

PRIMARY HEALTH CARE REPRESENTATIVE If it is determined that I lack decision making capacity to make health care decisions, I name the following individual to make health care decisions on my behalf:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, New Jersey 12345

Phone: 555-555-5555

Email: name@email.com

ALTERNATE HEALTH CARE REPRESENTATIVE. If my primary health care representative is not willing, able, or reasonably available, I name the following individual to make health care decisions on my behalf:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, New Jersey 12345

Phone: 555-555-5555

Email: name@email.com

AUTHORITY OF HEALTH CARE REPRESENTATIVE. My health care representative must follow my health care instructions in this document or any other instructions I have given to my representative. If I have not given health care instructions, then my representative must act in my best interest.

Limitations on Health Care Representative's Authority:

I do not wish to limit the authority of my health care representative at this time.

SIGNATURES

This document must be signed and dated by me. It also must either be verified by two witnesses (Option 1) OR a notary public (Option 2). It must be signed and dated when it is witnessed or verified.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: ____

Date signed: ____

If I cannot sign my name, I ask the below named person to sign for me.

Signature: ____

Printed Name:____

TWO WITNESSES (OPTION 1)

Witness One. In my presence on ______________________ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf and appeared to be of sound mind and free from duress and undue influence. I certify the following:

- I am at least 18 years of age.
- I am not named as a health care representative or an alternate health care representative in this document.

Witness One Signature: ____

Witness One Printed Name: _______________________________________

Witness One Address: ____

____

Witness One Phone: ____

Witness Two. In my presence on ____________________ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf and appeared to be of sound mind and free from duress and undue influence. I certify the following:

- I am at least 18 years of age.
- I am not named as a health care representative or an alternate health care representative in this document.

Witness Two Signature: _______________________________________

Witness Two Printed Name: ____________________________________

Witness Two Address: ____

____

Witness Two Phone: ____

OR

NOTARY PUBLIC (OPTION 2)

In my presence on ____________________ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

- I am not named as a health care agent or alternate health care agent in this document.

Notary Public Signature: ______________________________________

Commission Expiration Date: ___________________________________