NEW JERSEY PROXY DIRECTIVE
Durable Power of Attorney for Health Care

I _____ a single adult man and a member of the congregation of SOCIETY OF THE DIVINE WORD, an Order of Roman Catholic Priests/Brothers with its Provincial House at 1985 Waukegan Rd., Techny, Cook County, Illinois, have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decision. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. I expect my family to honor my wishes and not interfere in decisions about my healthcare. In no way does this manifests a lack of affection for my family. Rather, this expectation is consistent my with my vowed life as a DIVINE WORD PRIEST / BROTHER. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

(A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I hereby designate at point-in-time of office, my District Superior of New Jersey or my Provincial Superior of the SOCIETY OF THE DIVINE WORD, Chicago Province as my health care representatives 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 measures. I direct my representatives 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, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

(B) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

_____ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

(*If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement*.)

_____
_____
_____
_____

(C) COPIES: The original has been given to my District Superior in New Jersey and a copy is in my personnel file with the Provincial Superior of the SOCIETY OF THE DIVINE WORD, Chicago Province.

(D) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care 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 and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

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For _____

Signed this _____ day of _____, 20_____.

_____
Signature of Person Making Declaration (Declarant)

_____
(Type or Print Name of Declarant)

_____
Street Address

_____
City State Zip Code

(F) WITNESSES: 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, that he or she is personally known to me, and that 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, nor as an alternate health care representative.

_____
Signature of 1st Witness Date

_____
(Type or Print Name of Witness)

_____
Street Address

_____
City State Zip Code

_____
Signature of 2nd Witness Date

_____
(Type or Print Name of Witness)

_____
Street Address

_____
City State Zip Code