



Medical Administration
The Central Data Bank of Advance Medical Directives

SECOND SUPPLEMENT

**POWER OF ATTORNEY
FOR ISSUING DIRECTIVES AS TO THE MEDICAL CARE
OF A TERMINALLY-ILL PATIENT**

(Articles 37, 42)

This form is to be completed by persons wishing to give another person their power of attorney to decide on their behalf as what medical care shall be or be not given them, should they become terminally ill and incompetent, or terminally ill (death imminent) and incompetent.

I, the undersigned, _____, id. no. _____, year of birth _____, address _____

being competent within the meaning of the Terminally-Ill Patients Act, 2005 (hereafter — the Terminally-Ill Patients Act), hereby issue, under the provisions of the Terminally-Ill Patients Act, this power of attorney:

For the purpose of issuing this power of attorney I declare as follows:

(a) (1) My current medical state is:

- Generally healthy
- It has been determined that I am terminally ill

(2) I have received medical information[◇] from _____.

The said information is as follows:

[To be completed by a specialist physician, physician or nurse if the giver of the power of attorney has chosen Option C on p. 4]

[◇] Medical Information

- (1) A specialist physician shall give a person confirmed to be terminally ill information about his medical condition, including medical information about his condition which is relevant to his issuing directives, and medical information he may reasonably require for issuing advance medical directives.
- (2) A physician or nurse shall give a person not confirmed to be terminally ill medical information, which he may reasonably require for issuing advance medical directives.

- (b) I am aware that this power of attorney shall come into effect only once it has been determined that I am terminally ill, and I have been declared incompetent and I am suffering significantly, all the foregoing within the meaning of the Terminally-Ill Patients Act.
- (c) I am aware that should it be determined that I am terminally ill, but have not been declared incompetent, this power of attorney shall not come into effect and that my expressed wishes shall then take precedence.
- (d) I am aware that I may alter or revoke this power of attorney at any time, as long as I have not been declared incompetent within the meaning of the Act; the revocation shall take the form of a new power of attorney or a completed revocation form, a specimen of which is given in Supplement 4.
- (e) I am aware that this power of attorney shall remain valid for five years or for a period not exceeding five years, namely until: _____ (A date maybe specified here not more than five years from the date this power of attorney is signed.)

I hereby give power of attorney to the person noted below so that they may act on my behalf when I become terminally ill or terminally ill (death imminent) and am incompetent and cannot issue directives or give or refuse my consent to medical procedures for lack of the intellectual, mental or physical ability to do so, and am suffering significantly, and so that they may act in accordance with the directives in this power of attorney, I hereby give power of attorney to:

1. Mr./Ms. _____, id. no. _____,
 address: _____
 —

Should the above-mentioned person be unable or refuse to hold my power of attorney, I appoint in his/her stead to hold my power of attorney:

2. Mr./Ms. _____, id. no. _____,
 address: _____
 —

Significant Suffering

I am aware that only if I reach a state of significant suffering, as defined by me below, and shall be terminally ill and incompetent, will medical procedures not be performed on me in accordance with the advance medical directives in this document; significant suffering, as I define it, is—

[Check [in the box] whichever of the following is part of your definition of significant suffering]

- I require to be artificially fed
- I am unconscious
- I am quadriplegic
- I am in a state of dementia
- I require any of the following treatments —

- I am in one of the following states—

I am aware that if I have not defined above what I consider to be significant suffering, I shall be considered to be significantly suffering only if I am experiencing pain or suffering which a reasonable person would be ready to make a great effort to avoid or eliminate, even at the cost of significant injury to his quality of life or life expectancy, and that only if I am in that state, and am also terminally ill and incompetent, will these advance medical directives be followed.

(Choose and check one of the following options)

- A. With respect to any life-prolonging medical procedure, the holder of my power of attorney may take any decision required, including consenting or refusing consent to the procedure being administered to me.
- B. The holder of my power of attorney may act in my name only with respect to giving consent to an **exceptional** life-prolonging medical procedure [**even if my attending physicians consider the said procedure unjustifiable in the given circumstances**] but may not take a decision to refuse consent to any regular life-prolonging medical procedure.
- C. The holder of my power of attorney may take any decision with respect to the procedures enumerated below (C.1), where each procedure is marked either—
- Give me this life-prolonging medical procedure
or
 Do not give me this life-prolonging medical procedure

C.1 Should I reach a terminally ill state the following procedures should be performed/ not performed:

[Put in the box a clear '✓' if the procedure is covered by the power of attorney, as stated in Option C above, or leave empty if the procedure is not to be performed]

- (a) Resuscitation
- (b) Resuscitation by external cardiac massage
- (c) Resuscitation by endotracheal intubation
- (d) Resuscitation by administering resuscitation drugs
- (e) Resuscitation by electric shock
- (f) Connection to a ventilator with pacemaker (artificial breathing machine)

If this procedure is covered by the power of attorney, **please state if the holder of the power of attorney may specify that it is to be maintained for days/weeks/months/without time limit**

[Cross out whichever does not apply]

- (g) Dialysis
If this procedure is covered by the power of attorney, please state
if the holder of the power of attorney may specify that it is to be
halted if the dialysis is proving to have no useful effect?
- (h) Major surgery (e.g. amputating a necrotic limb, removing a necrotic internal organ)
- (i) Minor surgery (e.g. amputating a necrotic finger)
- (j) Radiotherapy (for malignant diseases)
- (k) Chemotherapy (for malignant diseases)
- (l) Antibiotic treatment for severe septicemia resistant to regular antibiotic treatment
- (m) Diagnostic tests (blood, X-rays, monitor)

C.2 Should I reach a terminally ill state (death imminent) the following procedures should be performed/ not performed:

[Put in the box a clear '✓' if the procedure is covered by the power of attorney, as stated in Option C above, or leave empty if the procedure is not to be performed]

- (a) Resuscitation
- (b) Resuscitation by external cardiac massage
- (c) Resuscitation by endotracheal intubation
- (d) Resuscitation by administering resuscitation drugs
- (e) Resuscitation by electric shock
- (f) Connection to a ventilator with pacemaker (artificial breathing machine)
If this procedure is covered by the power of attorney, please state
if the holder of the power of attorney may specify that it is to be
maintained for days/weeks/months/without time limit
 (Cross out whichever does not apply)
- (g) Dialysis
If this procedure is covered by the power of attorney, please state
if the holder of the power of attorney may specify that it is to be
halted if the dialysis is proving to have no useful effect?
- (h) Major surgery (e.g. amputating a necrotic limb, removing a necrotic internal organ)

- (i) Minor surgery (e.g. amputating a necrotic finger)
- (j) Radiotherapy (for malignant diseases)
- (k) Chemotherapy (for malignant diseases)
- (l) Antibiotic treatment for severe septicemia resistant to regular antibiotic treatment
- (m) Diagnostic tests (blood, X-rays, monitor)
- (n) Routine procedures, e.g. giving antibiotics, blood & blood products
- (o) Treating co-morbid illnesses, e.g. giving insulin
- (p) Giving food and liquids artificially
- (q) Giving palliative treatment and drugs

[* With regard to the subsidiary procedures specified in clauses (n) – (q) above, the Terminally-Ill Patients Act, 2005, states that directions that they not be performed can only apply in the case of a terminally ill patient (death imminent) who is incompetent and is suffering significantly.]

C.3 Instructions for other Emergency Situations***

** Emergency situation — a situation in which immediate treatment must be given if the patient is not to die.
 [Complete section C.3 only if you have directives for an emergency situation other than the ones enumerated above.]

C.4 Personal Directions not mentioned above

C.5 With respect to every question as to my treatment under the conditions specified above, I direct my attending physicians to apply first of all to the first-named holder of my power of attorney; should it not be possible to reach this person at the required time, or should he be unable or unwilling to fulfill his duties, I direct my attending physicians to apply to the second-named holder of my power of attorney.

D.1 In addition to this power of attorney I have also issued advance medical directives, and I direct my attending physicians to act in accordance with both the said medical directives and this power of attorney.
I am aware that, in the absence of a directive under Article D.2 below, concerning a contradiction between the said advance medical directives and this power of attorney, the directives shall take precedence, but that if the power of attorney shall have been given a considerable time after the directives, then an institutional board shall decide the precedence between them.

Check this box if
advance medical
directives given

D.2 I hereby direct that, in the event of a contradiction between my advance medical directives and a directive of the holder of my power of attorney, precedence shall go to—

Holder of power of attorney My advance medical directive
[Check one of the two boxes]

D.3 Further directives concerning a contradiction between an advance medical directive and a directive of the holder of my power of attorney:

DECLARATION AND SIGNATURE

Other persons informed of advance medical directives

[There is no duty to inform other persons, but doing so increases the chances that your directives will be effectively and correctly observed.

If you have not informed another person go directly to the next section, Signature.

If you have informed another person, please check the relevant boxes below clearly and insert the required data.]

I hereby declare that I have talked with the persons noted below about this document and that

—I have given them/
—I have not given them [Cross out whichever does not apply]
a copy of this document.

For each box checked, give name, address and telephone number of the person/persons informed.

- Spouse/
partner _____

- Relative _____

- Docto
r _____

- Attorne
y _____

- Rabbi/prie
st/ qadi _____

- Other
perso
n _____

Signature of Person Issuing this Power of Attorney

(The signatory must sign in the presence of 2 witnesses)

I sign this document after long and careful consideration and of my own free and autonomous will, and not in consequence of any familial, social or other pressure.

Signature: _____ Tel. no. (landline): _____

Tel. no. (mobile): _____ Date: _____

[Should the issuer of this power of attorney not speak or read Hebrew, please attach the affidavit of the person who translated for him/her the explanations and directives in the document.]

Signature of Witnesses

(The 2 witnesses must sign in each other's presence)

We, the undersigned, witness that the above signatory of this document —

- Is personally known to us
- Identified himself/herself to us by means of an identifying document which included a photo of the signatory
[Check one of the two above boxes]
- Signed this document in our presence and that he/she appears to us fully aware and speaking to the point, and that there is no sign of any pressure brought to bear on him/her.

- Further: I declare that I do not hold the signatory's power of attorney, nor am I a candidate to do so, nor do I have any economic or other interests involving the signatory.

(N.B. Relatives, a doctor, an attorney, or others may have economic interests involving the signatory)

Witness: Name: _____ Id. no. _____
Address: _____
Tel. no. (landline): _____ Tel. no. (mobile): _____
Signature: _____ Date: _____

Witness: Name: _____ Id. no. _____
Address: _____
Tel. no. (landline): _____ Tel. no. (mobile): _____
Signature: _____ Date: _____

Signature of Person who Gave the Signatory Medical Information

- (1) **To be completed if it has been determined that the issuer of these directives is terminally ill.**

I, _____, a specialist physician, hereby confirm that on (date) _____ I gave Mr./ Ms. _____ an explanation of his/her medical condition, including medical information about his/her condition relevant to his/her issuing directives and also medical information he/she may reasonably require for issuing a power of attorney. I also confirm that I explained to him/her the medical terms used in this form and that I wrote the précis of medical information that appears on p.1 of this document (Clause (a)(2)).

Name: _____ Id. no. _____
Address: _____
Tel. no. (landline): _____ Tel. no. (mobile): _____
Signature: _____ Date: _____

- (2) **To be completed if it has not been determined that the issuer of these directives is terminally ill.**

I, _____, a physician/ registered nurse, [Cross out whichever does not apply], hereby confirm that on (date) _____ I gave Mr./ Ms. _____ medical information he/she may reasonably require for issuing a power of attorney.

Name: _____ Id. no. _____
Address: _____
Tel. no. (landline): _____ Tel. no. (mobile): _____
Signature: _____ Date: _____

**The Central Data Bank of Advance Medical Directives
Ministry of Health**

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המרכז להנחיות רפואיות מקדימות

משרד הבריאות

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2nd Supplement- Power of Attorney

Before you send...

To avoid common mistakes while filling out Power of Attorney form, and to save unnecessary correspondence to correct the deficiencies, please check the following before sending the form.

<input type="checkbox"/> P. 1	- You must specify your current residential address <u>in accordance with your registration at the Population Registry</u> . If you wish you may also specify additional mailing address.
<input type="checkbox"/> P. 2	The person providing medical explanation (a physician or a registered nurse) must <u>WRITE</u> that they explained the medical terms in pp. 4 and 5 detailing several examples, and that they made sure you understood their explanation. This is <u>NOT</u> the place to detail your medical diagnoses. (Only in case that you are a dying patient, a medical specialist should write your medical diagnosis, in addition to explaining the medical terms as stated above).
<input type="checkbox"/> P. 3	You must specify name of the agent holding the Power of Attorney and his or her ID card No. It is recommended to add their phone No.
<input type="checkbox"/> P. 4	Choose only one of the following options: A, B, or C. If you chose option A, do not fill in the tables in pp. 5 and 6. Only if you chose option C you have fill in the tables on pp. 5 and 6 and mark in each of the items whether you would you like to receive life-prolonging medical care or to avoid receiving such medical care.
<input type="checkbox"/> P. 7	If you are also filling out Advance Medical Directives: - You must mark it (part C section 1) and send us the Advance Medical Directives form. - You must mark which provision should prevail in case of a conflict between a medical directive and the power of attorney
<input type="checkbox"/> P. 8	- You must sign and date at the bottom of the page. The date of your signature <u>MUST</u> be the same as the date of the witnesses' signatures in page 9. - It is recommended to add a phone No. for clarifications if needed.

<input type="checkbox"/> p. 9	<p>- At the top of the page there are two empty boxes (□) in which the witnesses MUST indicate how they know you.</p> <p>- The form MUST be signed by two witnesses, who are NOT first-degree relatives.</p> <p>The witnesses and you must sign on at the same time and in the same place, therefore the date of your signature in p. 8 MUST be the same as the date of the witnesses' signature.</p> <p>- "Signature of the person providing medical information" - the physician or the registered nurse must fill in all required information and sign.</p>
<input type="checkbox"/>	<p>Please attach a clear copy of your ID card including appendix.</p>
<input type="checkbox"/>	<p>Please send the form by registered mail to the following address: Ministry of Health The Central Data Bank of Advance Medical Directives Yirmiyahu St. 39, Jerusalem 9446724</p>

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 Ministry of Health**

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