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BURLINGTON COUNTY OFFICE:
137 High Street
Mt. Holly, NJ 08060

OCEAN COUNTY OFFICE:
230 Main Street
2nd Floor, Suite B
Toms River, NJ 08753

VIA FIRST CLASS MAIL

PLEASE REPLY TO:
CHERRY HILL OFFICE

HEALTHCARE POWER OF ATTORNEY/LIVING WILL QUESTIONNAIRE

Healthcare Power of Attorney- Is a legal document appointing a person to serve as your personal representative responsible for making sure your health care wishes are carried out as prescribed in your living will. This person also has the authority to make health care decisions for you if you are unable to do so.

Living Will- Is a legal document which provides instructions for your medical care when you are unable to make your own medical decisions

FULL LEGAL NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Under applicable New Jersey State law, you can only select one representative to serve as your health care representative at a time.

NAME OF PROPOSED HEALTH CARE REPRESENTATIVE

_____

RELATIONSHIP _____

STREET ADDRESS _____

CITY _____STATE _____ ZIP CODE _____

PLEASE NAME AN ALTERNATE HEALTH CARE REPRESENTATIVE IN CASE THE PERSON NAMED ABOVE IS UNWILLING OR UNABLE TO SERVE

NAME OF ALTERNATE REPRESENTATIVE

_____

RELATIONSHIP _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PLEASE NAME AN ALTERNATE HEALTH CARE REPRESENTATIVE IN CASE THE PERSON NAMED ABOVE IS UNWILLING OR UNABLE TO SERVE

NAME OF ALTERNATE REPRESENTATIVE

_____

RELATIONSHIP _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PLEASE INDICATE YOUR WISHES BY CHECKING ONE BOX BELOW:

_____ I WANT THIS PERSON TO BE ABLE TO ACT ON MY BEHALF IMMEDIATELY.

_____ I WANT THIS PERSON TO BE ABLE TO ACT ON MY BEHALF ONLY UPON CERTIFICATION BY A DOCTOR THAT I AM NO LONGER ABLE TO MAKE DECISIONS AND ACT FOR MYSELF.

CONFIRMATION OF INFORMATION AND INSTRUCTIONS:
I confirm the information provided by me in this form is complete and accurate and that the instructions I have provided reflect my wishes.

Signature _____ Print Name _____
Date _____