



# Ohio's Living Will

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## What you should know about Living Wills:

A **Living Will** is a document that allows you to establish, in advance, the type of medical care you would want to receive if you were to become permanently unconscious, or if you were to become terminally ill and unable to tell your physician or family what kind of life-sustaining treatments you want to receive. In addition, the latest edition of the Living Will allows you to specify your wishes regarding anatomical gifts (organ and tissue donation).

◆ A **Living Will** is used only in situations where you are unable to tell your physician what kind of health care services you want to receive. Before your **Living Will** goes into effect, you either must be:

(1) terminally ill (see definition as described in the Living Will Declaration Form) and unable to tell your physician your wishes regarding health-care services;

OR

(2) permanently unconscious. To be considered permanently unconscious, two physicians (one of whom must be a medical specialist in an appropriate field) must decide that you have no reasonable possibility of regaining consciousness.



Regardless of your condition, if you were able to speak and tell your physician your wishes about life-prolonging treatments, then the **Living Will** wouldn't be used – your physician would just talk directly with you about your wishes. A **Living Will** is used by the physician only if you are unable to tell him or her what you want to be done.

- ◆ A **Living Will** gives your physician the authority to withhold all life-sustaining treatment and permit you to die naturally and take no action to postpone your death, providing you with only that care necessary to make you comfortable and relieve your pain. This may include writing a DNR Order or withdrawing life-sustaining treatment such as CPR.

Such “comfort care” also may include removing nutrition and hydration (food and water) that is administered through feeding tubes or intravenously. If you wish to give your physician this authority if you become permanently unconscious, there is a space on the **Living Will** form that you must initial. If you want nutrition and hydration to be continued, regardless of the circumstances, don't initial this space.

- ◆ A **Living Will** can be honored only if your attending physician and others know about it. It is important to let your physician and your family and friends know that you have a **Living Will** before you become ill. After all, a **Living Will** can't be enforced if people don't know that it exists. In fact, it is a good idea for you to give your attending physician a copy of your **Living Will**. It also is important to give copies to family and friends so that, if necessary, they can advise your physician that you have a **Living Will**. In addition, it is important that you notify a health care facility that you have a **Living Will** when you are admitted as a patient. Please note: You **do not** have to go to court to put your **Living Will** into effect.
- ◆ Once the decision to withhold life-sustaining treatment is made, your physician must make a reasonable effort to notify the person or persons you designate in your **Living Will** or your closest family member.
- ◆ The law allows your family members to challenge a physician's determination that you have a terminal illness or that you are in a permanently unconscious state. This challenge is limited in nature and may be made only by your closest relatives. The law does not, however, allow your family members to challenge your own legally-documented decision not to be resuscitated.
- ◆ If you have both a **Living Will** and a **Health Care Power of Attorney**, the physician must comply with the wishes you state in your **Living Will**. In other words, your **Living Will** takes precedence over your **Health Care Power of Attorney**. There is a space on the **Living Will** form that you may check to let your physician and family and friends know that you have a **Health Care Power of Attorney**.
- ◆ You can revoke your **Living Will** at any time. You can do this by simply telling your physician and family that you have changed your mind and wish to revoke your **Living Will**. It is a good idea to ask anyone who has a copy of the document to return it to you.



## How to fill out the Living Will form:

You should use this form to let your physician and your family know what kind of life-sustaining treatments you want to receive if you become terminally ill or permanently unconscious and are unable to express your wishes.

### NOTE:

1. Read over all information carefully. Definitions are included as part of the form.
2. On the first two lines of the form, print your full name and birth date.
3. On the fourth page of the form, written in bold type face under *Special Instructions* is the statement that will give your physician permission to withhold food and fluids in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials on the line indicated in number 3.
4. The next section of the form (immediately below the *Special Instructions*) provides space for you to list the names, addresses and phone numbers of the contacts (usually family members and close friends) that you want your physician to notify when the **Living Will** goes into effect. **Remember, the Living Will goes into effect only when you are terminally ill or permanently unconscious and you cannot express your own wishes about the health care you receive.**
5. Following the "Anatomical Gift section" is a space to check whether or not you have completed a **Health Care Power of Attorney**. Immediately below this space is a place for you to date and sign the form. **Remember, the Living Will is not considered valid or effective unless you do one of the following:**

**First Option** – Date and sign the **Living Will** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.

OR

**Second Option** – Date and sign the **Living Will** in the presence of a notary public and have the **Living Will** notarized on the appropriate space provided on the form.

The following people may **not** serve as a witness to your **Living Will**:

- ◆ Anyone related to you by blood, marriage or adoption (this includes your husband or wife and your children);
- ◆ Your attending physician;
- ◆ If you are in a nursing home, the administrator of the nursing home.

6. Once you have filled out the **Living Will** and either signed it in the presence of witnesses or in the presence of a notary public, then it is a good idea to give a copy to your personal physician and any contacts you have listed in the **Living Will**. In some Ohio counties, people may be able to register their **Living Wills** with the county recorder. However, it is important to keep in mind that a registered **Living Will** form becomes a public record.



## State of Ohio Living Will Declaration Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable only to individuals in a terminal condition or a permanently unconscious state. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration controls over a Health Care Power of Attorney.

You should consider completing a new Living Will Declaration if your medical condition changes, or if you later decide to complete a Health Care Power of Attorney. If you have both documents, you should keep copies of both documents together, with your other important papers, and bring copies of both your Living Will and your Health Care Power of Attorney with you whenever you are a patient in a health care facility.



State of Ohio  
Living Will Declaration  
of

\_\_\_\_\_  
(Print Full Name)

\_\_\_\_\_  
(Birth Date)

I state that this is my Ohio Living Will Declaration. I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my wish that my dying not be artificially prolonged. If I am unable to give directions regarding the use of life-sustaining treatment when I am in a terminal condition or a permanently unconscious state, I intend that this Living Will Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

**Definitions.** Several legal and medical terms are used in this document. For convenience they are explained below.

**Anatomical gift** means a donation of all or part of a human body to take effect upon or after death.

**Artificially or technologically supplied nutrition or hydration** means the providing of food and fluids through intravenous or tube "feedings."

**Cardiopulmonary resuscitation or CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

**Declarant** means the person signing this document.

**Donor Registry Enrollment Form** means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

**Do Not Resuscitate or DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

**Health care** means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

**Health Care Power of Attorney** means another document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

**Life-sustaining treatment** means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

**Living Will Declaration** or **Living Will** means this document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

**Permanently unconscious state** means an irreversible condition in which I am permanently unaware of myself and my surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

**Terminal condition** or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

*[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]*

**Health Care if I Am in a Terminal Condition.** If I am in a terminal condition and unable to make my own health care decisions, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR and artificially or technologically supplied nutrition or hydration; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

**Health Care if I Am in a Permanently Unconscious State.** If I am in a permanently unconscious state, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

**Special Instructions.** By placing my initials at number 3 below, I want to specifically authorize my physician to withhold or to withdraw artificially or technologically supplied nutrition or hydration if:

1. I am in a permanently unconscious state; and
2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and
3. I have placed my initials on this line: \_\_\_\_\_

**Notifications.** [Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority:

[Note: If you do not name two contacts, you may wish to cross out the unused lines.]

First Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Second Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

### **Anatomical Gift (optional)**

**INSTRUCTIONS:** If you elect to make an anatomical gift, please complete and file the attached "Donor Registry Enrollment Form" with the Ohio Bureau of Motor Vehicles to ensure that your wishes will be honored.

\_\_\_\_ I wish to make an anatomical gift.

\_\_\_\_ I do not wish to make an anatomical gift.

Upon my death, the following are my directions regarding donation of all or part of my body:

In the hope that I, \_\_\_\_\_ (name of donor), may help others upon my death,

I hereby give the following body parts: \_\_\_\_\_

(indicate specific parts or all body parts) for any purpose authorized by law: transplantation, therapy, research or education. [Cross out any purpose that is unacceptable to you.]

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

**Donor Registry Enrollment Form.** I have completed the Donor Registry Enrollment Form:

\_\_\_\_\_ Yes \_\_\_\_\_ No

**NOTE:** If you modify or revoke your decision regarding anatomical gifts, please remember to make those changes in your Living Will, Health Care Power of Attorney, and Donor Registry Enrollment Form.

**No Expiration Date.** This Living Will Declaration will have no expiration date. However, I may revoke it at any time.

**Copies the Same as Original.** Any person may rely on a copy of this document.

**Out of State Application.** I intend that this document be honored in any jurisdiction to the extent allowed by law.

**Health Care Power of Attorney.** I have completed a Health Care Power of Attorney:

\_\_\_\_\_ Yes \_\_\_\_\_ No

**SIGNATURE**

*[See below for witness or notary requirements.]*

I understand the purpose and effect of this document and sign my name to this Living Will Declaration on \_\_\_\_\_, 20 \_\_\_\_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
DECLARANT

*[You are responsible for telling members of your family, the agent named in your Health Care Power of Attorney (if you have one), and your physician about this document. You also may wish to tell your religious advisor and your lawyer that you have signed a Living Will Declaration. You may wish to give a copy to each person notified.]*

*[You may choose to file a copy of this Living Will Declaration with your county recorder for safekeeping.]*

**WITNESSES OR NOTARY ACKNOWLEDGMENT**

*[Choose one.]*

*[This Living Will Declaration will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, or it is acknowledged before a Notary Public.]*

*[The following persons cannot serve as a witness to this Living Will Declaration: the agent or*

any successor agent named in your Health Care Power of Attorney; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]

**Witnesses.** I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in the Declarant's Health Care Power of Attorney, I am not the attending physician of the Declarant, I am not the administrator of a nursing home in which the Declarant is receiving care, and I am an adult not related to the Declarant by blood, marriage or adoption.

\_\_\_\_\_ residing at \_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Dated: \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_ residing at \_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Dated: \_\_\_\_\_, 20\_\_\_\_\_

**OR**

**Notary Acknowledgment.**

State of Ohio

County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned Notary Public, personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person whose name is subscribed to the above Living Will Declaration as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

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## DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)

(name of donor)

**INSTRUCTIONS:** In addition to completing the references to Anatomical Gifts in your Living Will and Ohio Health Care Power of Attorney you should also complete and file the "Donor Registry Enrollment Form" with the Ohio Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organ and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Ohio Donor Registry and will be accessible only to the appropriate organ, tissue or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions.

To register for the Donor Registry, please complete this form, detach and send the original to:

Ohio Bureau of Motor Vehicles  
ATTN: Record Clearance Unit  
P.O. Box 16784  
Columbus, Ohio 43216-6784

Make a copy of this form and retain it as part of your Living Will Declaration.

*[This form must be signed by two witnesses. If the donor is under the age of 18, a parent or legal guardian must sign as one of the two witnesses.]*

*[This form should be used to state your intentions to be included in or removed from the Ohio Bureau of Motor Vehicles Donor Registry.]*

Please indicate below:

Please include me in the Donor Registry

Please remove me from the Donor Registry



Print or type full name of living donor \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Driver's License or ID Card Number \_\_\_\_\_

Social Security Number \_\_\_\_\_

In the hope that I, \_\_\_\_\_ (name of donor), may help others upon my death, the following are my directions regarding donation of all or part of my body.

\_\_\_ On my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

**OR**

\_\_\_ On my death, I make an anatomical gift of the following specified organ, tissues, or eyes for any purposes indicated below:

- |                                     |                                   |  |                                       |
|-------------------------------------|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Any or all | <input type="checkbox"/> Liver    | <input type="checkbox"/> Bone/ligament | <input type="checkbox"/> Heart valves |
| <input type="checkbox"/> Heart      | <input type="checkbox"/> Kidneys  | <input type="checkbox"/> Veins         | <input type="checkbox"/> Skin         |
| <input type="checkbox"/> Lung       | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Eyes          | <input type="checkbox"/> Other        |

Any purpose authorized by law or, specifically as indicated below:

- Transplantation
- Therapy
- Research
- Education
- Advancement of medical science
- Advancement of dental science

\_\_\_\_\_  
Signature of Donor

\_\_\_\_\_  
Date of Birth of Donor \_\_\_\_\_ Date Signed \_\_\_\_\_

\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Witness \_\_\_\_\_ Date \_\_\_\_\_



# Ohio's Health Care Power of Attorney

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## What you should know about a Health Care Power of Attorney:

A **Health Care Power of Attorney** is a document that allows you to name a person to act on your behalf to make health care decisions for you if you become unable to make them for yourself. **This person becomes an attorney-in-fact for you.**

- ◆ A **Health Care Power of Attorney** is different from a financial power of attorney that you use to give someone authority over your financial matters.
- ◆ The person you appoint as your **attorney-in-fact**, by completing the **Health Care Power of Attorney** form, has the power to authorize and refuse medical treatment for you. **This authority is recognized in all medical situations when you are unable to express your own wishes.** Unlike a **Living Will**, it is not limited to situations in which you are terminally ill or permanently unconscious. For example, your physician or the hospital may consult with your attorney-in-fact should you be injured in a car accident and become temporarily unconscious.



✦ There are five **limitations** on the authority of your attorney-in-fact:

1. **An attorney-in-fact has limited authority to order that life-sustaining treatment be withdrawn from you.** Your attorney-in-fact may order that life-sustaining treatment be refused or withdrawn only if you have a terminal condition or if you are in a permanently unconscious state. And even then, the attending physician and, if applicable, the consulting physician, must confirm that diagnosis, and your attending physician(s) must determine that you have no reasonable possibility of regaining decision-making ability.
2. **Your attorney-in-fact does not have the authority to order the withdrawal of “comfort care.”** Comfort care is any type of medical or nursing care that would provide you with comfort or relief from pain.
3. **If you are pregnant, your attorney-in-fact cannot order the withdrawal of life-sustaining treatment unless certain conditions are met.** Life-sustaining treatment cannot be withdrawn if doing so would terminate the pregnancy unless there is substantial risk to your life or two physicians determine that the fetus would not be born alive.
4. **Your attorney-in-fact may order that nutrition and hydration be withdrawn only if you are in a terminal condition or permanently unconscious state and two physicians agree that nutrition and hydration will no longer provide comfort or alleviate pain.** If you want to give your attorney-in-fact the authority to withhold nutrition and hydration if you were to become permanently unconscious, you must indicate this in the appropriate section of the **Health Care Power of Attorney** form. If you also have a **Living Will**, it should be consistent with your **Health Care Power of Attorney** regarding the withholding of nutrition and hydration. In other words, if you indicate in your **Health Care Power of Attorney** that it is permissible for your attorney-in-fact to order that nutrition and hydration be withheld, then you also should indicate in your **Living Will** that it is permissible for your physician to withhold nutrition and hydration.
5. **If you previously have given consent for treatment (before becoming unable to communicate), your attorney-in-fact cannot withdraw your consent unless certain conditions are met.** Either your physical condition must have changed and/or the treatment you approved is no longer of benefit or the treatment has not been proven effective.



If you have a **Health Care Power of Attorney** and a **Living Will**, health care workers must follow the wishes you state in your **Living Will**, once the **Living Will** becomes effective. In other words, your **Living Will** takes precedence over your **Health Care Power of Attorney**.

You can change your mind and revoke your **Health Care Power of Attorney** at any time. You can do this simply by telling your attorney-in-fact, your physician and your family that you have changed your mind and wish to revoke your **Health Care Power of Attorney**. In this case, it is probably a good idea to ask for a copy of the document back from anyone to whom you may have given it.

### How to fill out the Health Care Power of Attorney form:

You should use this form to appoint someone to make health care decisions for you if you should become unable to make them for yourself.

#### NOTE:

1. Read over all information carefully. Definitions are included as part of the form.
2. On the first two lines of the form, print your full name and birth date.
3. Under, "Naming of My Agent," fill in the name of the person you are appointing as your attorney-in-fact, the agent's current address and telephone number. You may name alternate agents on the indicated spaces, if you choose not to name alternate agents, you may wish to cross out the unused lines. You may not name your attending physician or the administrator of any nursing home where you are receiving care as your attorney-in-fact.
4. On the fifth page of the form, written in bold face type under *Special Instructions*, is the statement that will give your physician permission to withhold food and water in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials on the line indicated in number three.
5. The form provides a section where you may write additional instructions and impose additional limitations that you may consider appropriate to document. You may attach additional pages if needed. You should include all attached pages with any copy(ies) you make and you should note the attached pages on the form itself in the related area.



6. Following "Additional Instructions or Limitations" is a section where you indicate whether or not you have a **Living Will**. Immediately below this area are spaces to date and sign the form. Remember, the **Health Care Power of Attorney** is not considered valid or effective unless you do one of the following:

**First Option** – Date and sign the **Health Care Power of Attorney** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.

OR

**Second Option** – Date and sign the **Health Care Power of Attorney** in the presence of a notary public and have the **Health Care Power of Attorney** notarized on the appropriate space provided on the form.

The following people may **not** serve as a witness to your **Health Care Power of Attorney**:

- ◆ The Agent and any successor agent named in this document;
- ◆ Anyone related to you by blood, marriage, or adoption, including your spouse and your children;
- ◆ Your attending physician or, if you are in a nursing home, the administrator of the nursing home.

7. NOTE: The section titled NOTICE TO ADULT EXECUTING THIS DOCUMENT is required by law to be part of the document and must accompany it and any copies distributed.



State of Ohio  
Health Care Power of Attorney  
of

\_\_\_\_\_  
(Print Full Name)

\_\_\_\_\_  
(Birth Date)

I state that this is my Health Care Power of Attorney and I revoke any prior Health Care Power of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

This Health Care Power of Attorney is in effect only when I cannot make health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

*Definitions.* Several legal and medical terms are used in this document. For convenience they are explained below.

**Agent or attorney-in-fact** means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

**Anatomical gift** means a donation of all or part of a human body to take effect upon or after death.

**Artificially or technologically supplied nutrition or hydration** means the providing of food and fluids through intravenous or tube "feedings."

**Cardiopulmonary resuscitation or CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.



**Comfort care** means any measure taken to diminish pain or discomfort, but not to postpone death.

**Donor Registry Enrollment Form** means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

**Do Not Resuscitate or DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

**Health care** means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

**Health Care Power of Attorney** means this document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

**Life-sustaining treatment** means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

**Living Will Declaration or Living Will** means another document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

**Permanently unconscious state** means an irreversible condition in which I am permanently unaware of myself and surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

**Principal** means the person signing this document.

**Terminal condition or terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

*[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]*

**Naming of My Agent.** The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name: \_\_\_\_\_

Agent's Current Address: \_\_\_\_\_

Agent's Current Telephone Number: \_\_\_\_\_

**Naming of Alternate Agents.** [Note: You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, you may wish to cross out the unused lines.]

Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

First Alternate Agent:

Second Alternate Agent:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Telephone: \_\_\_\_\_

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

**Guidance to Agent.** My agent will make health care decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make health care decisions in my best interests. My agent will determine my best interests after considering the benefits, the burdens, and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

**Authority of Agent.** My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following: *[Note: Cross out any authority that you do not want your agent to have.]*

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.
2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.
3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.
4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.
5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.
6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.
7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.
8. To select, employ, and discharge health care personnel and services providing home health care and the like.
9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.
10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:

- (a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and
- (b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and
- (c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

***Special Instructions.*** By placing my initials at number 3 below, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if:

- 1. I am in a permanently unconscious state; and
- 2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and
- 3. I have placed my initials on this line: \_\_\_\_\_

***Limitations of Agent's Authority.*** I understand that under Ohio law, there are five limitations to the authority of my agent:

- 1. My agent cannot order the withdrawal of life-sustaining treatment unless I am in a terminal condition or a permanently unconscious state, and two physicians have confirmed the diagnosis and have determined that I have no reasonable possibility of regaining the ability to make decisions; and
- 2. My agent cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and
- 3. If I am pregnant, my agent cannot refuse or withdraw informed consent to health care if the refusal or withdrawal would end my pregnancy, unless the pregnancy or health care would create a substantial risk to my life or two physicians determine that the fetus would not be born alive; and



**No Expiration Date.** This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

**Guardian.** I intend that the authority given to my agent will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate my agent to serve as the guardian of my person, without bond.

**Enforcement by Agent.** My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

**Release of Agent's Personal Liability.** My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

**Copies the Same as Original.** Any person may rely on a copy of this document.

**Out of State Application.** I intend that this document be honored in any jurisdiction to the extent allowed by law.

**Living Will.** I have completed a Living Will: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Anatomical Gift(s).** I have made my wishes known regarding organ and tissue donation in my Living Will: \_\_\_\_\_ Yes \_\_\_\_\_ No

**Donor Registry Enrollment Form.** I have completed the Donor Registry Enrollment Form: \_\_\_\_\_ Yes \_\_\_\_\_ No

**SIGNATURE**

*[See next page for witness or notary requirements.]*

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on \_\_\_\_\_, 20\_\_\_\_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
PRINCIPAL

*[You are responsible for telling members of your family and your physician about this document and the name of your agent. You also may wish, but are not required to tell your religious advisor and your lawyer that you have signed a Health Care Power of Attorney. You may wish to give a copy to each person notified.]*

*[You may choose to file a copy of this Health Care Power of Attorney with your county recorder for safekeeping.]*

**WITNESSES OR NOTARY ACKNOWLEDGMENT**

[Choose one.]

[This Health Care Power of Attorney will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, or it is acknowledged before a Notary Public.]

[The following persons **cannot** serve as a witness to this Health Care Power of Attorney: the agent; any successor agent named in this document; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]

**Witnesses.** I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in this document, I am not the attending physician of the Principal, I am not the administrator of a nursing home in which the Principal is receiving care, and I am an adult not related to the Principal by blood, marriage or adoption.

\_\_\_\_\_ residing at \_\_\_\_\_  
Signature

\_\_\_\_\_, \_\_\_\_\_  
Print Name

Dated: \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_ residing at \_\_\_\_\_  
Signature

\_\_\_\_\_, \_\_\_\_\_  
Print Name

Dated: \_\_\_\_\_, 20\_\_\_\_\_

**OR**

Notary Acknowledgment.

State of Ohio

County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned Notary Public, personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person whose name is subscribed to the above Health Care Power of Attorney as the Principal, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

## NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);**

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:

(a) You are in a terminal condition or in a permanently unconscious state.

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

**(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.**

**(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:**

**(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;**

**(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.**

**(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the above requirements of (4)(c)(i) and (ii) above.**

**(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.**

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

*[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]*

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

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For more information about organ and tissue donation, please contact [www.donatelifefohio.org](http://www.donatelifefohio.org) or your local organ procurement organization.

**Lifeline of Ohio**

770 Kinnear Road, Suite 200  
Columbus, OH 43212  
(614) 291-5667  
(800) 525-5667  
[www.lifelineofohio.org](http://www.lifelineofohio.org)

**LifeBanc**

20600 Chagrin Boulevard, Suite 350  
Cleveland, OH 44122-5343  
(216) 752-5433  
(800) 558-5433  
[www.lifebanc.org](http://www.lifebanc.org)

**Life Center Organ Donor Network**

2925 Vernon Place, Suite 300  
Cincinnati, OH 45219-2425  
(513) 558-5555  
(800) 981-5433  
[www.lifecont.org](http://www.lifecont.org)

**Life Connection of Ohio**

**Dayton Regional Office**

40 Wyoming Street  
Dayton, OH 45409  
(937) 223-8223  
(800) 535-9206  
[www.lifeconnectionofohio.org](http://www.lifeconnectionofohio.org)

**Life Connection of Ohio**

**Toledo Regional Office**

3661 Briarfield Boulevard, Suite 105  
Maumee, OH 43537-9102  
(419) 893-1618  
(800) 262-3443  
[www.lifeconnectionofohio.org](http://www.lifeconnectionofohio.org)

It is important to let your loved ones know that you have Advance Directives. This card is provided for your use. Please complete the card and place it in your wallet or purse so your wishes will be known to medical professionals.

<input type="checkbox"/> I have a Living Will.	Forms located: _____
<input type="checkbox"/> I have a Healthcare Power of Attorney Form.	My Healthcare Power of Attorney(s)/Agent(s):
<input type="checkbox"/> I am an Anatomical Gifts Donor and have registered with the Bureau of Motor Vehicles.	Primary Name: _____
Name: _____	Phone: _____
Address: _____	Secondary Name: _____
City: _____	Phone: _____
State: _____	Zip: _____
Phone: _____	