Ohio Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will Declaration
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will Declaration

NOTICE: This form of a Living Will Declaration is designed to serve as evidence of an individual's desire that life-sustaining medical treatment, including artificially- or technologically-supplied nutrition and hydration, be withheld or withdrawn if the individual is unable to communicate and is in a terminal condition or a permanently-unconscious state. If you would choose not to withhold or withdraw any or all forms of life-sustaining treatment, you have the legal right to so choose and you might want to state your medical treatment preferences in writing in another form of Declaration. Under Ohio law, a Living Will Declaration may be relied on only for individuals in a terminal condition or a permanently-unconscious state. If you wish to direct your medical treatment in other circumstances, you should consider preparing a Durable Power of Attorney for Health Care.

I, being of sound mind and not subject to duress, fraud, or undue influence, intending to create a Living Will Declaration under Chapter 2133 of the Ohio Revised Code, do voluntarily make known my desire that my dying shall 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, it is my intention that this Living Will Declaration shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment. I am a competent adult who understands and accepts the consequences of such refusal and the purpose and effect of this document **(initial all the following that you choose)**:

In the event I am in a terminal condition, I declare and direct that my attending physician shall **(initial all that you choose):**

[ ] Administer NO life-sustaining treatment, including cardiopulmonary resuscitation;

[ ] Withdraw life-sustaining treatment, including cardiopulmonary resuscitation, if such treatment has commenced, and in the case of cardiopulmonary resuscitation, issue a do-not-resuscitate order;

[ ] Permit me to die naturally and provide me with only the care necessary to make me comfortable and to relieve my pain but not to postpone my death.

In the event I am in a permanently-unconscious state, I declare and direct that my attending physician shall **(initial all that you choose):**

[ ] Administer NO life-sustaining treatment, including cardiopulmonary resuscitation, except for the provision of artificially- or technologically-supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal;

[ ] Withdraw such treatment, including cardiopulmonary resuscitation, if such treatment has commenced, and, in the case of cardiopulmonary resuscitation, issue a do-not-resuscitate order;

[ ] Permit me to die naturally and provide me with only that care necessary to make me comfortable and to relieve my pain but not to postpone my death.

[ ] In addition, **if I have initialed the foregoing box,** I authorize my attending physician to withhold, or in the event that treatment has already commenced, to withdraw the provision of artificially- or technologically-supplied nutrition and hydration, if I am in a permanently-unconscious state and if my attending physician and at least one other physician who has examined me determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that such nutrition or hydration will not or will no longer serve to provide comfort to me or alleviate my pain.

OTHER DIRECTIONS: In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, he or she shall make a good faith effort and use reasonable diligence to notify one (1) of the persons named below in the following order of priority:

(1) _____ (name), _____ (relationship), of _____ (address).

(2) _____ (name), _____ (relationship), of _____ (address).

[ ] I have a durable power of attorney for health care. **(Initial if true).**

For purposes of this Living Will Declaration:
(1) "Life-Sustaining Treatment" means any medical procedure, treatment, intervention, or other measure including artificially- or technologically-supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.
(2) "Terminal Condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one (1) other physician who has examined me, both of the following apply: (a) There can be no recovery; and (b) Death is likely to occur within a relatively short time if life-sustaining treatment is not administered.
(3) "Permanently-Unconscious State" means a state of permanent unconsciousness that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one (1) other physician who has examined me, is characterized by both of the following: (a) I am irreversibly unaware of myself and my environment, and (b) There is a total loss of cerebral cortical functioning, resulting in my having no capacity to experience pain or suffering.

Selection of Health Care Agent
(Durable Power of Attorney for Health Care)

NOTICE: 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, refuse to give informed consent, or 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 (1) 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, OR
(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 paragraph [4] below, the attorney-in-fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under paragraph [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 will no longer serve to provide comfort to you or alleviate your pain, then, subject to paragraph [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 (1) 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, (b) Your attending physician and at least one (1) 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 will no longer 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 will no longer 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 requirements of paragraphs (4)(c)(i) and (4)(c)(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, review health care records, and consent to the disclosure of health care records. You can limit that right in this document if you so choose. 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 generally 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 (2) 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.

I, intending to create a Durable Power of Attorney for Health Care under Chapter 1337 of the Ohio Revised Code, do hereby designate and appoint:

_____ (name),
of _____ (address),
as my attorney-in-fact who shall act as my agent to make health care decisions for me as authorized in this document.

I hereby grant to my agent full power and authority to make all health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so, at any time during which I do not have the capacity to make or communicate informed health care decisions for myself. My agent shall have the authority to give, withdraw, or refuse to give informed consent to any medical or nursing procedure, treatment, intervention, or other measure used to maintain, diagnose, or treat my physical or mental condition. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent by me or, if I have not made my desires known, that are, in the judgment of my agent, in my best interests.

Where necessary or desirable to implement the health care decisions that my agent is authorized to make pursuant to this document, my agent has the power and authority to do any and all of the following:
(1) If I am in a terminal condition, to give, withdraw, or refuse to give informed consent to life-sustaining treatment, including the provision of artificially- or technologically-supplied nutrition or hydration;
(2) If I am in a permanently-unconscious state, to give informed consent to life-sustaining treatment, withdraw, or refuse to give informed consent to life-sustaining treatment; provided, however, my agent is not authorized to refuse or direct the withdrawal of artificially- or technologically-supplied nutrition or hydration unless I have specifically authorized such refusal or withdrawal in this document;
(3) To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all of my medical and health care facility records;
(4) To execute on my behalf any releases or other documents that may be required in order to obtain this information;
(5) To consent to the further disclosure of this information if necessary;
(6) To select, employ, and discharge health care personnel, such as physicians, nurses, therapists, and other medical professionals, including individuals and services providing home health care, as my agent shall determine to be appropriate;
(7) To select and contract with any medical or health care facility on my behalf, including, but not limited to, hospitals, nursing homes, assisted-residence facilities, and the like; and
(8) To execute on my behalf any or all of the following: (a) documents that are written consents to medical treatment or written requests that I be transferred to another facility, (b) documents that are Do Not Resuscitate Orders, Discharge Orders, or other similar orders, and (c) any other document necessary or desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

WITHDRAWAL OF NUTRITION AND HYDRATION WHEN IN A PERMANENTLY- UNCONSCIOUS STATE.
[ ] **If I have initialed the foregoing box,** my agent may refuse, or in the event treatment has already commenced, withdraw informed consent to the provision of artificially- or technologically-supplied nutrition and hydration if I am in a permanently-unconscious state and if my attending physician and at least one (1) other physician who has examined me determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that such nutrition or hydration will not or will no longer serve to provide comfort to me or alleviate my pain.

This Durable Power of Attorney for Health Care shall not be affected by my disability or by lapse of time. This Durable Power of Attorney for Health Care shall have no expiration date. Any invalid or unenforceable power, authority, or provision of this instrument shall not affect any other power, authority, or provision or the appointment of my agent to make health care decisions. I hereby revoke any prior Durable Powers of Attorney for Health Care executed by me under Chapter 1337 of the Ohio Revised Code.

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below**:

[ ] any organs or parts **OR**

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law **OR**

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

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.

Attached also please find a Donor Registry Enrollment Form. To register for the Donor Registry, please complete this form and send it to the Ohio Bureau of Motor Vehicles. This form must be signed by two witnesses. If the donor is under age eighteen, one witness must be the donor's parent or legal guardian. **The choices made on that form should be identical to the choices made in this document.**

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will Declaration
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____
City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____

On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care:

Signature _____ Date _____

Ohio Donor Registry Enrollment Form

Please initial one of the following choices:

_____Please include me in the donor registry.

_____ Please remove me from the donor registry.

Full Name (please print)_____

Mailing address_____
_____
_____

Phone _____ Date of Birth_____

Driver License or ID Card No._____

Social Security No. _____

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes that I have initialed below:

[ ] any organs or parts OR

[ ] eyes	[ ] bone and connective tissue	[ ] skin
[ ] heart	[ ] kidney(s)	[ ] liver
[ ] lung(s)	[ ] pancreas	[ ] other _____

for the purposes of:

[ ] any purpose authorized by law OR

[ ] transplantation	[ ] research	[ ] therapy
[ ] medical education	[ ] other limitations _____	

_____ _____
Signature of donor registrant Date

_____
Witness signature

_____
Witness signature”

Please send this form to the Ohio Bureau of Motor Vehicles