State of Ohio Advance Directives:

Health Care Power of Attorney

Living Will Declaration

I have completed a **Health Care Power of Attorney**:	Yes ☐	No ☐
I have added special notes to my Health Care Power of Attorney:	Yes ☐	No ☐
I have included **Nomination of Guardian(s)** on my Health Care Power of Attorney:	Yes ☐	No ☐
I have completed a **Living Will Declaration**:	Yes ☐	No ☐
I have added special instructions to my Living Will Declaration:	Yes ☐	No ☐

[NOTE: Whenever you sign a new advance directive document, it automatically will revoke prior similar documents unless you provide otherwise. [R.C. §1337.14 and R.C. §2133.04 (C)]

[NOTE: If you make changes to an advance directive, remember to make similar changes to your other advance directives.]

OHIO STATE BAR ASSOCIATION
Connect. Advance. Succeed.

State of Ohio
Health Care Power of Attorney

[R.C. §1337]

_____
(Full Name)

_____
(Birth Date)

This is my Health Care Power of Attorney. I revoke all prior Health Care Powers 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.

I understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions. However, this does not require or imply that a court must declare me incompetent.

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. *[You can refuse or discontinue a feeding tube or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]*

Bond means an insurance policy issued to protect the ward's assets from theft or loss caused by the Guardian of the Estate's failure to properly perform his or her duties.

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and/or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Guardian means the person appointed by a court through a legal procedure to make decisions for a ward. A **Guardianship** is established by such court appointment.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

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 a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

Ward means the person the court has determined to be incompetent. The ward's person, financial estate, or both, is protected by a guardian the court appoints and oversees.

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 and relationship: _____

Address: _____

Telephone number(s): _____

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to obtain my protected health care information immediately and at any future time.**

Guidance to Agent. My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, 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.

Naming of alternate agent(s). If my agent named above is not immediately available or is unwilling or unable to make decisions for me, then I name, in the following order of priority, the persons listed below as my alternate agents *[cross out any unused lines]*:

X out area if not used

First alternate agent's name and relationship: _____

Address: _____

Telephone number(s): _____

Second alternate agent's name and relationship: _____

Address: _____

Telephone number(s): _____

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.

Authority of Agent. Except for those items I have crossed out and subject to any choices I have made in this Health Care Power of Attorney, my agent has full and complete authority to make all health care decisions for me. This authority includes, but is not limited to, the following:

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.

2. If I am in a terminal condition and I do not have a Living Will Declaration that addresses treatment for such condition, to make decisions regarding 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, interventions or other measure.

4. To request, review and receive any information, verbal or written, regarding my physical or mental condition, 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 person who acts while relying on 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, if I am in a place where the terms of this document are not enforced.

11. To complete and sign for me the following:

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

Special Instructions. [These instructions apply only if I DO NOT have an active Living Will Declaration.]

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to refuse or, if treatment has started, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND 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.** [R.C. §1337.13(E)(2)(a) and (b)]

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

1. My agent does not have authority to refuse or withdraw informed consent to health care necessary to provide comfort care.

2. My agent does not have the authority to refuse or withdraw informed consent to health care if I am pregnant, if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to my life, or unless my attending physician and at least one other physician to a reasonable degree of medical certainty determines that the fetus would not be born alive.

3. My agent cannot order the withdrawal of life-sustaining treatment, including artificially or technologically supplied nutrition or hydration, unless I am in a terminal condition or in a permanently unconscious state and two physicians have determined that life-sustaining treatment would not or would no longer provide comfort to me or alleviate my pain.

4. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

Additional Instructions or Limitations. I may give additional instructions or impose additional limitations on the authority of my agent. Below are my specific instructions or limitations:

[If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write "None" below.]

NOMINATION OF GUARDIAN

[R.C. §1337.28 (A) and R.C. §2111.121]

[You may, but are not required to, use this document to nominate a guardian, should guardianship proceedings be started, for your person or your estate.]

I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship. [R.C. §2111.121(C)]

I understand that the court will honor my nominations except for good cause shown or disqualification. [R.C. §2111.121(B)]

I understand that, if a **guardian of the person** is appointed for me, such guardian's duties would include making day-to-day decisions of a personal nature on my behalf, such as food, clothing and living arrangements, but this or any subsequent Health Care Power of Attorney would remain in effect and control health care decisions for me, unless determined otherwise by the court. The court will determine limits, suspend or terminate this or any subsequent Health Care Power of Attorney, if they find that the limitation, suspension or termination is in my best interests. [R.C. §1337.28 (C)]

I intend that the authority given to my agent in my Health Care Power of Attorney will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate the person(s) below in the order listed as **guardian of my person.**

☐ By writing my initials, signature, a check mark or other mark in this box, I nominate my agent and alternate agent(s), if any, to be **guardian of my person**, in the order named above.

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order *[cross out any unused lines]:*

X out area if not used

Guardian of my person's name and relationship: _____

Address: _____

Telephone number(s): _____

Alternate guardian of my person's name and relationship: _____

Address: _____

Telephone number(s): _____

Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. The guardian of the estate is required to be bonded, unless bond is waived in writing or the court finds it unnecessary.

☐ By placing my initials, signature, check or other mark in this box, I nominate my agent or alternate agent(s), if any, as **guardian of my estate**, in the order named above.

If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order *[cross out any unused lines]:*

X out area if not used

Guardian of my estate and relationship: _____

Address: _____

Telephone number(s): _____

Alternate guardian of my estate and relationship: _____

Address: _____

Telephone number(s): _____

☐ By placing my initials, signature, check or other mark in this box, I direct that bond be waived for the guardian or successor **guardian of my estate**. [R.C. §1337.28 (B)]

If I do **not** make any mark in this box, it means that I expect the guardian or successor guardian of my estate to be bonded. [R.C. §1337.28 (B)]

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.

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 be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests. [R.C. §1337.35]

Copies are the Same as Original. Any person may rely on a copy of this document. [R.C. §1337.26(D)]

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §1337.26(C)]

I have completed a **Living Will Declaration**: Yes ☐ No ☐

SIGNATURE of PRINCIPAL

I understand that I am responsible for telling members of my family and my physician, my lawyer, my religious advisor and others about this Health Care Power of Attorney. I understand I may give copies of this Health Care Power of Attorney to any person.

I understand that I may file a copy of this Health Care Power of Attorney with the probate court for safekeeping. [R.C. §1337.12(E)(3)]

I understand that I must sign this Health Care Power of Attorney and state the date of my signing, and that my signing either must be witnessed by two adults who are eligible to witness my signing OR the signing must be acknowledged before a notary public. [R.C. §1337.12]

I sign my name to this Health Care Power of Attorney

on _____ , at_____ , Ohio.

_____

Principal

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES [R.C. §1337.12(B)]

[The following persons CANNOT serve as a witness to this Health Care Power of Attorney:

- *Your agent, if any;*
- *The guardian of your person or estate, if any;*
- *Any alternate or successor agent or guardian, if any;*
- *Anyone related to you by blood, marriage, or adoption (for example, your spouse and children);*
- *Your attending physician; and*
- *The administrator of any nursing home where you are receiving care.]*

I attest that the principal signed or acknowledged this Health Care Power of Attorney in my presence, and that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____ /_____ /_____

Witness One's Signature | Witness One's Printed Name | Date

_____

Witness One's Address

_____ /_____ /_____

Witness Two's Signature | Witness Two's Printed Name | Date

_____

Witness Two's Address

OR, if there are no witnesses:

NOTARY ACKNOWLEDGMENT [R.C. §1337.12]

State of Ohio
County of _____ ss.

On_____, before me, the undersigned notary public, personally appeared

_____, principal of the above Health Care Power of Attorney, 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: _____

My Commission is Permanent ☐

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.
>
> (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**

Notice as required by Ohio Revised Code §1337.17

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.

(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.

Notice 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 when you 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.

Notice as required by Ohio Revised Code §1337.17

ADDENDUM

This notice was not updated when certain provisions of the law regarding the Health Care Power of Attorney were changed in March 2014. Please be advised of the following changes:

You may, but are not required to, authorize your agent to get your health information, including information that is protected by law and otherwise not available to your agent. You can authorize your agent to have access to your health information immediately upon your signing of this document or at any later time, even though you are still able to make your own health care decisions.

You may also, but are not required to, use this document to name guardians for you or your estate should guardianship proceedings be started.

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 takes precedence 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 a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.]

Ohio
Living Will Declaration

[R.C. §2133]

_____
(Full Name)

_____
(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations 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.

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 direction that my dying not be artificially prolonged. [R.C. §2133.02 (A)(1]]

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care. [R.C.§2133.03(B)(2)]

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Anatomical gift means a donation of part or all of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research or education.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. *[You can refuse or discontinue a feeding tube, or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]*

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

Declarant means the person signing the Living Will Declaration.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

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 a declarant's attending physician and one other physician who has examined the declarant, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time. [R.C. §2133.04(A)]

Copies the Same as Original. Any person may rely on a copy of this document. [R.C. §2133.02(C)]

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §2133.14]

I have completed a **Health Care Power of Attorney**: Yes ☐ No ☐

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 *[cross out any unused lines]*: [R.C. §2133.05(2)(a)]

X out area if not used

First contact's name and relationship: _____

Address: _____

Telephone number(s): _____

Second contact's name and relationship: _____

Address: _____

Telephone number(s): _____

Third contact's name and relationship: _____

Address: _____

Telephone number(s): _____

If I am in a **TERMINAL CONDITION** and unable to make my own health care decisions, OR if I am in a **PERMANENTLY UNCONSCIOUS STATE** and there is no reasonable possibility that I will regain the capacity to make informed decisions, then I direct my physician to let me die naturally, providing me only with **comfort care**.

For the purpose of providing comfort care, I authorize my physician to:

1. Administer no life-sustaining treatment, including CPR;
2. Withhold or withdraw artificially or technologically supplied nutrition or hydration, provided that, if I am in a permanently unconscious state, I have authorized such withholding or withdrawal under **Special Instructions** below and the other conditions have been met;
3. Issue a DNR Order; and
4. Take no action to postpone my death, providing me with only the care necessary to make me comfortable and to relieve pain.

***Special Instructions*.**

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND 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.** [R.C. §2133.02(A)(3) and R.C. §2133.08]

Additional instructions or limitations.

[If the space below is not sufficient, you may attach additional pages.
If you do not have any additional instructions or limitations, write "None" below.]

[The "anatomical gift" language provided below is required by ORC §2133.07(C). Donate Life Ohio recommends that you indicate your authorization to be an organ, tissue or cornea donor at the Ohio Bureau of Motor Vehicles when receiving a driver license or, if you wish to place restrictions on your donation, on a Donor Registry Enrollment Form (attached) sent to the Ohio Bureau of Motor Vehicles.]

[If you use this living will to declare your authorization, indicate the organs and/or tissues you wish to donate and cross out any purposes for which you do not authorize your donation to be used. Please see the attached Donor Registry Enrollment Form for help in this regard. In all cases, let your family know your declared wishes for donation.]

ANATOMICAL GIFT (optional)

In the hope that I may help others upon my death, I hereby give the following body parts for the following purposes: *[Complete both sections.]*

Section 1. Body Parts. Check "All organs, tissue and eyes" or all that apply below that box.

☐ All organs, tissue and eyes. If you check this box, do not check any other boxes in Section 1 and proceed to Section 2.

☐ Heart	☐ Lungs	☐ Liver (and associated vessels)	☐ Pancreas/Islet Cells
☐ Small Bowel	☐ Intestines	☐ Kidneys (and associated vessels)	☐ Eyes/Corneas
☐ Heart Valves	☐ Bone	☐ Tendons	☐ Ligaments
☐ Veins	☐ Fascia	☐ Skin	☐ Nerves

Section 2. Purposes. Check "All purposes" or all that apply below that box.

☐ All Purposes. If you check this box, do not check any boxes below.

☐ Transplantation ☐ Therapy ☐ Research ☐ Education

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

SIGNATURE of DECLARANT

I understand that I am responsible for telling members of my family, the agent named in my Health Care Power of Attorney (if I have one), my physician, my lawyer, my religious advisor and others about this Living Will Declaration. I understand I may give copies of this Living Will Declaration to any person.

I understand that I must sign (or direct an individual to sign for me) this Living Will Declaration and state the date of the signing, and that the signing either must be witnessed by two adults who are eligible to witness the signing OR the signing must be acknowledged before a notary public. [R.C. §2133.02]

I sign my name to this Living Will Declaration

on_____, at _____, Ohio.

_____

Declarant

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES [R.C. §2133.02(B)(1)]

[The following persons CANNOT serve as a witness to this Living Will Declaration:

- *Your agent in your Health Care Power of Attorney, if any;*
- *The guardian of your person or estate, if any;*

- *Any alternate agent or guardian, if any;*
- *Anyone related to you by blood, marriage or adoption (for example, your spouse and children);*
- *Your attending physician; and*
- *The administrator of the nursing home where you are receiving care.]*

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.

_____ /_____ /_____

Witness One's Signature | Witness One's Printed Name | Date

_____

Witness One's Address

_____ /_____ /_____

Witness Two's Signature | Witness Two's Printed Name | Date

_____

Witness Two's Address

OR, if there are no witnesses,

NOTARY ACKNOWLEDGMENT [R.C. §2133.02(B)(2)]

State of Ohio
County of _____ ss.

On _____, before me, the undersigned notary public, personally appeared _____, declarant of the above Living Will Declaration, 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: _____

My Commission is Permanent: ☐

State of Ohio
Donor Registry Enrollment Form
Notice to Declarant

The purpose of the Donor Registry Enrollment Form is to document your wish to donate organs, tissues and/or corneas at the time of your death.

This form should be completed only if you have **NOT** already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state identification card; online through the BMV website; or previously through a paper form. If you wish to make an anatomical gift or modify an existing registration this form must be sent to the BMV to ensure your wishes for organ, tissue and/or cornea donation will be honored. This document will serve as your authorization to recover the organs, tissue and/or corneas indicated at the time of your death, if medically possible.

In submitting this form your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ, tissue and cornea recovery agencies at the time of death. You are encouraged to share your wishes with your next of kin so they are aware of your intentions to be a donor.

This form can also be used to amend or revoke your wishes for donation. The completed form should be mailed to:

Ohio Bureau of Motor Vehicles
Attn: Records Request
P. O. Box 16583
Columbus, OH 43216-6583

Frequently asked questions about organ, tissue and cornea donation are addressed on page three of this section. If you have more specific questions, contact information for the state's organ and tissue recovery agencies is also listed, and you are encouraged to contact them or visit their websites.

Ohio Donor Registry Enrollment Form

If you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state ID, the Ohio Donor Registry Form must be filed with the BMV to ensure your wishes concerning organ and tissue donation will be honored. This document will serve as your authorization to recover the organs and/or tissues indicated at the time of your death, if medically possible. In submitting this form, your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ and tissue recovery agencies at the time of death. Be sure to share your wishes with loved ones so they are aware of your intentions. This form can also be used to amend or revoke your wishes for donation.

To register, please complete and mail this enrollment form to:
Ohio Bureau of Motor Vehicles
Attn: Records Request
P.O. Box 16583
Columbus, OH 43216-6583

PLEASE PRINT

LAST NAME	FIRST	MIDDLE
MAILING ADDRESS		
CITY	STATE	ZIP
PHONE	DATE OF BIRTH	STATE OF OHIO DL/ID CARD # **OR** SOCIAL SECURITY #

DONOR REGISTRY ENROLLMENT OPTIONS

OPTION 1

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

OPTION 2

☐ Upon my death, I make an anatomical gift of the following organs, tissues, and/or eyes selected below:

☐ All organs, tissues and eyes

ORGANS

☐ Heart
☐ Lungs
☐ Liver (and associated vessels)
☐ Kidneys (and associated vessels)
☐ Pancreas/Islet Cells
☐ Intestines
☐ Small Bowel

TISSUES

☐ Eyes/Corneas
☐ Heart Valves
☐ Bone
☐ Tendons
☐ Ligaments
☐ Veins
☐ Fascia
☐ Skin
☐ Nerves

For the following purposes authorized by law:

☐ All purposes ☐ Transplantation ☐ Therapy ☐ Research ☐ Education

OPTION 3

☐ Please take me out of the Ohio Donor Registry.

SIGNATURE OF DONOR REGISTRANT	DATE
X	

Organ and Tissue Donation in Ohio

One individual can save or improve the quality of life for people who suffer from organ failure, congenital defects, bone cancer, orthopedic injuries, burns, blindness and more. One organ donor can save up to 8 lives by donating heart, lungs, kidneys, pancreas, small intestine and liver. More than 123,000 Americans are on the national waiting list for a life-saving organ transplant; 3,400 in Ohio. Statistically, 18 people in the U.S. die every day while waiting for transplants. If you register as a donor, be sure to share the decision with your family members.

Who can become a donor? All individuals over the age of 15½ can register and give advance authorization for donation. Medical suitability for donation is determined at the time of death. If a minor dies before the age of 18, a parent can amend or revoke the donation decision.

Are there age limits for donors? People of all ages and medical histories should consider themselves potential donors. Newborns as well as senior citizens have been organ donors. Medical condition at the time of death will determine what organs and tissues can be donated.

If I join the Donor Registry, will it affect the quality of medical care I receive at the hospital? No, doctors at hospitals are concerned with caring for the patient in front of them and are not involved with donation and transplantation. Every effort is made to save your life before donation is considered.

Will donation disfigure my body? Can there be an open casket funeral? Donation does not disfigure the body and does not interfere with or delay a funeral, including open casket services.

Are there any costs to my family for donation? The donor's family does NOT pay for the cost of the donation. All costs related to donation of organs, eyes and tissues are paid by the designated recovery agency.

Does my religion approve of donation? All major religions support organ, eye and tissue donation as an unselfish act of charity.

Can I sell my organs? No. The National Organ Transplant Act makes it illegal to sell human organs and tissue. Violators are subject to fines and imprisonment. Among the reasons for this rule is the concern of Congress that buying and selling of organs might lead to inequitable access to donor organs, with the wealthy having an unfair advantage.

How are organs distributed? Donor organs are matched to recipients through a federally-regulated system based on a number of factors including blood type, body size, medical urgency, time on waiting list and geographical location.

Can I be an organ and tissue donor and also donate my body to science? Total body donation takes precedence over organ and tissue donation. If you wish to donate your entire body, you must make arrangements with a medical school or research facility prior to your death. Medical schools, research facilities and other agencies study bodies to gain greater understanding of anatomy and disease mechanisms in humans. This research is also vital to saving and improving lives.

Does the registry authorize living donation? No, living donation is not authorized by the registry. It is possible to donate a kidney, or part of a liver or lung while alive, but that is arranged on an individual basis through specific transplant centers.

For more information on donation, contact one of the state's four federally designated organ procurement organizations:

Northeastern Ohio	Western Ohio	Central and Southeastern Ohio	Southwestern Ohio
LifeBanc	Life Connection of Ohio	Lifeline of Ohio	LifeCenter
www.lifebanc.org	www.lifeconnectionofohio.org	www.lifelineofohio.org	www.lifepassiton.org
216.752.5433	937.223.8223	877.223.6667	513.558.5555

DNR ORDER FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

Patient Name:	Patient Birth Date:
Optional Patient or Authorized Representatives Signature	
Printed name of Physician, APRN or PA*	Date
REQUIRED Signature of Physician, APRN or PA	Phone
REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA or Ohio medical license number.	

CHECK ONLY ONE BOX BELOW

☐ **DNR Comfort Care — Arrest:** Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will be implemented.

☐ **DNR Comfort Care:** The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:

- Conduct an initial assessment
- Perform Basic Medical Care
- Clear airway of obstruction or suction
- If necessary for comfort or to relieve distress, may administer oxygen, CPAP or BiPAP
- If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death
- If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN or PA)

Providers Will Not:

- Perform CPR
- Administer resuscitation medications with the intent of restarting the heart or breathing
- Insert an airway adjunct
- De-fibrillate, cardiovert or initiate pacing
- Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided **immunities under section 2133.22 of the Revised Code.** This DNR order is effective until revoked and may not be altered. Any medical orders, instructions or information other than those required elements of the form itself, that are written on this order form are not transportable and are not provided protections or immunities.

* A DNR may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

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