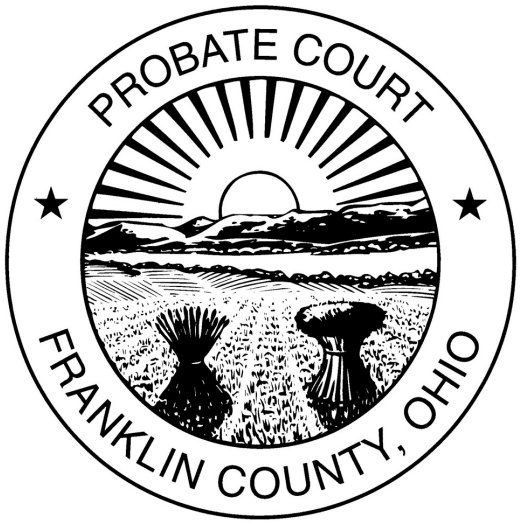
State of Ohio

Living Will Declaration

Donor Registry Enrollment Form

Health Care Power of Attorney

For: _____



Issued as a Public Service
by
ROBERT G. MONTGOMERY, JUDGE
Franklin County Probate Court
373 South High Street
22nd Floor
Columbus, Ohio 43215-6311

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life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state.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.

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association

OSBA Ohio State Bar Association

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:	Second Contact:
Name: _____	Name: _____
Address: _____	Address:_____
_____	_____
Telephone:_____	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: _____

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

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association

OSBA Ohio State Bar Association

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 XXX - XX - _____

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:

☐ Any or all	☐ Liver	☐ Bone/ligament	☐ Heart valves
☐ Heart	☐ Kidneys	☐ Veins	☐ Skin
☐ Lung	☐ Pancreas	☐ Eyes	☐ 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

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.

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association

OSBA Ohio State Bar Association

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:

Name: _____

Address: _____

_____

Telephone:_____

Second Alternate Agent:

Name: _____

Address: _____

_____

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

4. My agent cannot order the withdrawal of artificially or technologically supplied nutrition or hydration unless I am terminally ill or permanently unconscious and two physicians agree that nutrition or hydration will no longer provide comfort or relieve pain and, in the event that I am permanently unconscious, I have given a specific direction to withdraw nutrition or hydration elsewhere in this document; and

5. 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. *[Note: On the lines below you may write in additional instructions or limitations. Here you may include any specific instructions or limitations you consider appropriate, such as instructions to refuse specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. If the space below is not sufficient, you may attach additional pages. If you include additional instructions or limitations here and your wishes change, you should complete a new Health Care Power of Attorney and tell your agent about the changes. If you do not have any additional instructions or limitations, you may wish to write "None" below or cross out the unused lines.]*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.

(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.

For more information about organ and tissue donation, please contact www.donatelifeohio.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

LifeBanc
20600 Chagrin Boulevard, Suite 350
Cleveland, OH 44122-5343
(216) 752-5433
(800) 558-5433
www.lifebanc.org

Life Center Organ Donor Network
2925 Vernon Place, Suite 300
Cincinnati, OH 45219-2425
(513) 558-5555
(800) 981-5433
www.lifecnt.org

Life Connection of Ohio
Dayton Regional Office
40 Wyoming Street
Dayton, OH 45409
(937) 223-8223
(800) 535-9206
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

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.

Forms located: _____

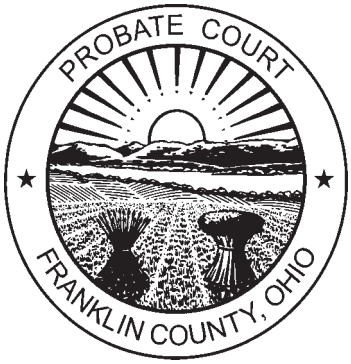
My Healthcare Power of Attorney(s)/Agent(s):
Primary
Name: _____
Phone: _____
Secondary
Name: _____
Phone: _____

❑ I have a Living Will.
❑ I have a Healthcare Power of Attorney Form.
❑ I am an Anatomical Gifts Donor and have registered with the Bureau of Motor Vehicles.

Name: _____
Address: _____
City: _____
State: _____ Zip: _____ Phone: _____

Emergency Health Care Information

Advance Directives Wallet Card



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ROBERT G. MONTGOMERY, JUDGE
Franklin County Probate Court
373 South High Street
22nd Floor
Columbus, Ohio 43215-6311

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Hospice &
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OSMA
Ohio State Medical Association

Ohio Hospital Association

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