OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Adult Executing this Document

REQUIRED NOTICE

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

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

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

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions your-self, 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.

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REQUIRED NOTICE (CONTINUED)

(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.

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REQUIRED NOTICE (CONTINUED)

(B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASON-ABLE 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 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.

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REQUIRED NOTICE (CONTINUED)

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.

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 attorney in fact of your attending physician, or an employee or attorney in fact 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 attorney in fact is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or attorney in fact is a competent adult and you and the employee or attorney in fact are members of the same religious order.

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

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

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REQUIRED NOTICE (CONTINUED)

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

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

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK YOUR LAWYER TO EXPLAIN IT TO YOU.

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PRINT YOUR NAME AND BIRTH DATE

____
(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.

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ATTORNEY IN FACT

Naming of My Attorney in Fact. The person named below is my attorney in fact who will make health care decisions for me as authorized in this document.

Attorney in Fact's Name:
____

Attorney in Fact's Current Address:
____

Attorney in Fact's Current Telephone Number:
____

Naming of Alternate Attorney in Facts. [Note: You do not need to name alternate attorney in facts. You also may name just one alternate attorney in fact. If you do not name alternate attorney in facts or name just one alternate attorney in fact, you may wish to cross out the unused lines.]

Should my attorney in fact 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 attorney in facts:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE ATTORNEYS IN FACT

First Alternate Attorney in Fact:	Second Alternate Attorney in Fact:
Name: __________________	Name: __________________
Address: ________________	Address: ________________
________________________	________________________
Telephone: ______________	Telephone: ________________

Any person can rely on a statement by any alternate attorney in fact 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.

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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

I direct that:

____

(attach additional pages if needed)

Authority of Attorney in Fact. My attorney in fact 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 attorney in fact to have.]

CROSS OUT AND INITIAL ANY AUTHORITY THAT YOU DO NOT WANT YOUR ATTORNEY IN FACT TO HAVE

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my attorney in fact, 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 attorney in fact 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 attorney in fact'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 attorney in fact.

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.

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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:

CROSS OUT ANY AUTHORITY THAT YOU DO NOT WANT YOUR ATTORNEY IN FACT TO HAVE

(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 attorney in fact is authorized to make pursuant to this document.

Special Instructions. By placing my initials at number 3 below, I want to **SPECIFICALLY AUTHORIZE MY ATTORNEY IN FACT 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

PLACE INITIALS HERE ONLY IF YOU WANT TO AUTHORIZE YOUR ATTORNEY IN FACT TO REFUSE ARTIFICIAL NUTRITION OR HYDRATION

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: _________________

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Limitations of Attorney in Fact's Authority. I understand that under Ohio law, there are five limitations to the authority of my attorney in fact:

GENERAL LIMITATIONS ON ATTORNEY IN FACT'S AUTHORITY

1. My attorney in fact 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 attorney in fact cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and

3. If I am pregnant, my attorney in fact 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 attorney in fact 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 attorney in fact 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 no longer significantly effective to achieve the purpose for which I chose the health care.

Additional Limitations.

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR ATTORNEY IN FACT'S AUTHORITY

My attorney in fact's authority is subject to the following limitations:

____

____

____

____

____

____

____

____

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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 attorney in fact will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start; I nominate my attorney in fact to serve as the guardian of my person, without bond.

Enforcement by Attorney in Fact. My attorney in fact may take for me, at my expense, any action my attorney in fact considers advisable to enforce my wishes under this document.

Release of Attorney in Fact's Personal Liability. My attorney in fact 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.

INITIAL THE BLANKS TO INDICATE OTHER ADVANCE-PLANNING DOCUMENTS YOU HAVE COMPLETED

Living Will. I have completed a Living Will (Declaration):
_________ Yes _________ No

Anatomical Gift(s). I have made my wishes known regarding organ and tissue donation in my Living Will (Declaration):
____________Yes ____________ No

Donor Registry Enrollment Form. I have completed the Donor Registry Enrollment Form: _________ Yes ___________ No

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USE ALTERNATIVE NO. 1 IF YOU PLAN TO HAVE YOUR DOCUMENT WITNESSED (P. 13)

USE ALTERNATIVE NO. 2 IF YOU PLAN TO HAVE YOUR DOCUMENT NOTARIZED (P. 14)

The law requires that you have your Declaration witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public,

   OR

2. Sign your document, or direct another to sign it, in the presence of two adult witnesses. Your witnesses **cannot** be:
   - related to you,
   - your attorney in fact,
   - your doctor, or
   - the administrator of the nursing home in which you are receiving care.

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SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

REQUIRED STATEMENT IF YOU FILLED OUT PART I

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Alternative No. 1: Sign before witnesses.

Signature
I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on ___________________, 20 __, at

___________________, Ohio.

____
Signature

____
Printed Name

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 attorney in fact 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.

Witness 1

Signature: ____

Print Name: ____

residing at: ____

Dated: ___________________________ , 20_______

Witness 2

Signature: ____

Print Name: ____

residing at: ____

Dated: ___________________________ , 20_______

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

Alternative No. 2: Sign before a notary public.

Signature
I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on ____________________, 20 __, at

____________________, Ohio.

____
Signature

____
Printed Name

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: ____________________

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Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

OHIO DECLARATION

Notice to Declarant

The purpose of this 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 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.

NOTICE

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 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 Declaration controls over a Health Care Power of Attorney.

You should consider completing a new 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.

DEFINITIONS

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.

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DEFINITIONS

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 attorney in fact 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.

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.

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PRINT YOUR NAME AND DATE OF BIRTH

State of Ohio Declaration of

____

(Print Full Name)

____

(Birth Date)

I state that this is my Ohio 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 Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

INSTRUCTIONS

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.

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IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION WITHDRAWN OR WITHHELD, YOU MUST INITIAL HERE

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.

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: 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.

PRINT THE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ANYONE YOU WISH TO BE INFORMED IN THE EVENT YOUR PHYSICIAN DETERMINES LIFE-SUSTAINING TREATMENT SHOULD BE WITHDRAWN OR WITHHELD

First Contact:

Name: ____

Address: ____

____

Telephone: ____

Second Contact:

Name: ____

Address: ____

____

Telephone:____

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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I direct that:

____

(attach additional pages if needed)

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.

INITIAL TO INDICATE WHETHER YOU WANT TO MAKE AN ANATOMICAL GIFT

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

_____ I wish to make an anatomical gift.
_____ I do not wish to make an anatomical gift.

PRINT YOUR NAME

INDICATE WHICH ORGANS AND TISSUES OR ALL ORGANS AND TISSUES THAT YOU ARE WILLING TO DONATE

In the hope that I, ____ (name of donor), may help others upon my death, I hereby give the following body parts: ____
____
____
____
____,
for any purpose authorized by law, including:

CROSS OUT ANY PURPOSE THAT IS UNACCEPTABLE TO YOU

1. transplantation,
2. therapy,
3. research, or
4. education.

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.

INITIAL HERE TO INDICATE WHETHER YOU HAVE COMPLETED THE DONOR REGISTRY ENROLLMENT FORM THAT FOLLOWS THIS DECLARATION

Donor Registry Enrollment Form. I have completed the attached Donor Registry Enrollment Form: ___________Yes _____________No

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No Expiration Date.

This 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.

CHECK HERE IF YOU HAVE COMPLETED A HEALTH CARE POWER OF ATTORNEY

Health Care Power of Attorney. I have completed a Health Care Power of Attorney: ___________ Yes ___________ No

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USE ALTERNATIVE NO. 1 IF YOU PLAN TO HAVE YOUR DOCUMENT WITNESSED (P. 9)

USE ALTERNATIVE NO. 2 IF YOU PLAN TO HAVE YOUR DOCUMENT NOTARIZED (P. 10)

The law requires that you have your Declaration witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public,

   OR

2. Sign your document, or direct another to sign it, in the presence of two adult witnesses. Your witnesses **cannot** be:
   - related to you,
   - your doctor, or
   - the administrator of a nursing home in which you are receiving care.

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SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

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Alternative No. 1: Sign before witnesses.

Signature
I understand the purpose and effect of this document and sign my name to this Declaration on ____________________, 20 __, at

____________________, Ohio.

____
Signature

____
Printed Name

Witnesses. I attest that the Declarant signed or acknowledged this Declaration 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 attorney in fact for the Declarant, 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.

Witness 1

Signature: ____

Print Name: ____

residing at: ____

Dated: ______________________________ , 20________

Witness 2

Signature: ____

Print Name: ____

residing at: ____

Dated: ______________________________ , 20________

Alternative No. 2: Sign before a notary public.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

Signature

I understand the purpose and effect of this document and sign my name to this Declaration on ____________________, 20 __, at

____________________, Ohio.

____
Signature

____
Printed Name

Notary Acknowledgment.

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

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 Declaration as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

____
Notary Public

My Commission Expires: ____________________

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Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

TO ENROLL IN THE OHIO ORGAN DONATION REGISTRY, COMPLETE THIS FORM AND MAIL IT TO THE ADDRESS INDICATED

OHIO DONOR REGISTRY ENROLLMENT - PAGE 1 OF 1

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 SSN

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 my organs, tissues and/or eyes selected below.

☐ ALL ORGANS, TISSUES AND EYES

ORGANS

☐ HEART
☐ LUNGS
☐ LIVER (AND ASSOCIATED VESSELS)
☐ KIDNEY (AND ASSOCIATED VESSELS)
☐ PANCREAS/ISLET CELLS
☐ INTESTINES
☐ SMALL BOWEL

TISSUES

☐ EYES/CORNEAS
☐ HEART VALVES
☐ BONE
☐ TENDONS
☐ LIGAMENTS
☐ VEINS
☐ FASCIA
☐ SKIN
☐ SKIN

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 **X**	DATE

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You Have Filled Out Your Health Care Directive, Now What?

1. Your Ohio Durable Power of Attorney for Health Care and Ohio Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.

2. Give photocopies of the signed originals to your attorney in fact and alternate attorney in fact, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your attorney in fact(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your forms in Google Health, or another online medical records management service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning. You can read more about Google Health at http://www.caringinfo.org/googlehealth.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.

6. Remember, you can always revoke your Ohio documents.

7. Be aware that your Ohio document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**