

ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS: This form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. This form also lets you express an intention to donate your bodily organs and tissues following your death. Lastly, this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named.

STATE OF OHIO - LIVING WILL DECLARATION

NOTICE TO DECLARANT:

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medical treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if the individual is unable to communicate and is in a terminal condition or a permanently unconscious state.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

I, _____, (the "Declarant"), being of sound mind and not subject to duress, fraud or undue influence, intending to create a Living Will Declaration under Chapter 2133 of the Ohio Revised Code, do voluntarily make known my desire that my dying shall not be artificially prolonged. If I am unable to give directions regarding the use of life-sustaining treatment when I am in a terminal condition or a permanently unconscious state, it is my intention that this Living Will Declaration shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment. I am a competent adult who understands and accepts the consequences of such refusal and the purpose and effect of this document.

In the event I am in a terminal condition, I declare and direct that my attending physician shall:

administer no life-sustaining treatment, including cardiopulmonary resuscitation;

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

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

In the event I am in a permanently unconscious state, I declare and direct that my attending physician shall:

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

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

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

_____ IN ADDITION, IF I HAVE PLACED MY INITIALS ON THE LINE AT THE BEGINNING OF THIS PARAGRAPH, I AUTHORIZE MY ATTENDING PHYSICIAN TO WITHHOLD, OR IN THE EVENT THAT TREATMENT HAS ALREADY COMMENCED, TO WITHDRAW THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY SUPPLIED NUTRITION AND HYDRATION, IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT SUCH NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

DIRECTIONS TO CONSULT:

_____ If I have placed my initials on the line at the beginning of this paragraph, then in the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, he or she shall make a good faith effort and use reasonable diligence to notify one of the persons named below in the following order of priority:

_____	_____
(name)	(relationship)

_____	_____
(street address)	(city, state, zip)

_____	_____
(home or cell tel. #)	(bus. or other tel. #)

_____	_____
(name)	(relationship)

(street address)

(city, state, zip)

(home or cell tel. #)

(bus. or other tel. #)

For purposes of this Living Will Declaration:

(A) "Life-sustaining treatment" means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.

(B) "Terminal Condition" means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, 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.

(3) "Permanently Unconscious State" means a state of permanent unconsciousness that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by my attending physician and one other physician who has examined me, is characterized by both of the following:

(a) I am irreversibly unaware of myself and my environment, and

(b) There is a total loss of cerebral cortical functioning, resulting in my having no capacity to experience pain or suffering.

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

_____.

OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____.

PRIMARY PHYSICIAN: (OPTIONAL)

I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(name of physician)

(address) (city) (state) (zip code)

(phone)

DONATION OF ORGANS AT DEATH: (OPTIONAL)

Upon my death: (mark applicable box)

(a) I give any needed organs, tissues, or parts, OR

(b) I give the following organs, tissues, or parts only.

(c) My gift is for the following purposes: (strike any of the following you do not want)

- (1) Transplant
- (2) Therapy
- (3) Research
- (4) Education

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

I execute this declaration, as my free and voluntary act, on this _____ day of _____, 20__,

in the City of _____, County of _____, State of _____.

(signature)

(INSTRUCTIONS: This advance health care directive will not be valid for making health care decisions unless it is either: (1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (2) acknowledged before a notary public.)

I declare under penalty of perjury under the laws of the state of (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community health care facility, the operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

I further declare under the laws of penalty of perjury of the state of that I am neither related to the patient by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any portion of the patient's estate upon the patient's death under a will existing when the advance directive is executed or by operation of law.

Signed at _____, , on this ____ day of _____, 20__.

(name and address of first witness)

(name and address of second witness)

State of _____	
County of _____	

On this the _____ day of _____, 20__, before me, the undersigned, a notary public in and for said County and State, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature of Notary