

# OHIO

## Advance Directive

### Planning for Important Healthcare Decisions

Courtesy of CaringInfo

[www.caringinfo.org](http://www.caringinfo.org)

800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **ACTION STEPS**

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

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5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or 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.

## **INTRODUCTION TO YOUR OHIO ADVANCE HEALTH CARE DIRECTIVE**

This packet contains a legal document, an **Ohio Advance Health Care Directive**, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Your Ohio Advance Directive has two legal documents, the **Ohio Durable Power of Attorney for Health Care** and the **Ohio Living Will Declaration**, as well as an **Organ Donation Enrollment** form. You may complete one or both of the two legal documents, depending on your advance planning needs. You only need to complete the Donor Registry Enrollment form if you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles.

### **How do I make my Ohio Durable Power of Attorney for Health Care and/or Ohio Living Will Declaration legal?**

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself.

Your signature must be either

- witnessed before a notary public or
- witnessed by two adult who are not:
  - Related to you,
  - Your doctor,
  - The administrator of the nursing home in which you are receiving care,
  - You agent (in the case of the Durable Power of Attorney for Health Care)

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you. Your agent cannot be:

- Your doctor;
- An administrator of a nursing home in which you are receiving care;
- An employee or agent of your doctor or your treating healthcare facility, unless he or she is related to you or is a member of your religious order (you are both monks, nuns, priests, etc.)
- A person you have a civil or criminal protective order against; or
- A person that you currently divorcing or from whom you are legally separated.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

### **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

### **When does my agent's authority become effective?**

Your Ohio Durable Power of Attorney for Health Care (agent) only becomes effective when your doctor determines that you have lost the capacity to make informed healthcare decisions for yourself.

Your Ohio Living will Declaration only becomes effective when your doctor determines that you have lost the capacity to make informed healthcare decisions for yourself and you are terminally ill or you are permanently unconscious. Any written instructions that you provide must be followed by your agent. You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

### **Agent Limitations**

Your agent, if you appoint one, does not have authority to authorize removal or artificial life support unless you are determined to have a terminal condition.

Your agent will be bound by the current laws of Ohio as they regard pregnancy and termination of pregnancies.

### **What if I change my mind?**

You may revoke your Ohio Durable Power of Attorney for Health Care and/or Living Will Declaration at any time and in any manner. Your revocation becomes effective once your doctor receives notification of your revocation. If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

## **What other important facts should I know?**

Your agent, if you appoint one, may make decisions about life-sustaining treatment only if you are terminally ill or permanently unconscious.

Before your agent can consent to the withholding or withdrawal of artificial nutrition and hydration on your behalf, you must check and initial the statement printed in bold letters on page 6 of the Ohio Durable Power of Attorney for Health Care.

Your agent does not have authority to refuse or withdraw care necessary to provide comfort care.

At the end of the Ohio Durable Power of Attorney for Health Care are several pages that the state of Ohio requires and that should be read before executing the document.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form **MUST** be signed by a healthcare provider and **MUST** be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

**OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE  
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**State of Ohio  
Health Care Power of Attorney  
Of**

---

PRINT YOUR NAME  
AND BIRTH DATE

(Print Full Name)

---

(Birth Date)

This is my Health Care Power of Attorney. I revoke all prior Health Care Powers of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

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

### **Definitions**

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

**Terminal condition** means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

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

DEFINITIONS

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**Naming of My Agent.** The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name and Relationship:

\_\_\_\_\_

Agent's Current Address:

\_\_\_\_\_

Agent's Current Telephone Number:

\_\_\_\_\_

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

**Guidance to Agent.** My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, my agent will determine my best interests after considering the benefits, the burdens and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

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

First Alternate Agent:

Second Alternate Agent:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_ 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.

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBERS OF YOUR  
AGENT

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBERS OF YOUR  
ALTERNATE AGENTS

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

1. To consent to the administration of pain---relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death.

2. If I am in a terminal condition and I do not have a Living Will Declaration that addresses treatment for such condition, to make decisions regarding life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, interventions or other measure.

4. To request, review and receive any information, verbal or written, regarding my physical or mental condition, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any person who acts while relying on this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

CROSS OUT AND  
INITIAL ANY  
AUTHORITY THAT  
YOU DO NOT WANT  
YOUR AGENT TO  
HAVE

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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, if I am in a place where the terms of this document are not enforced.

11. To complete and sign for me the following:

(a) Consents to health care treatment, or to the issuing of Do Not Resuscitate (DNR) Orders or other similar orders; and

(b) Requests to be transferred to another facility, to be discharged against health care advice, or other similar requests; and

(c) Any other document desirable or necessary to implement health care decisions that my agent is authorized to make pursuant to this document.

**Special Instructions.** By placing my initials, signature, check or other mark on this line, I **specifically authorize my agent to refuse or, if treatment has started, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration** if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain: \_\_\_\_\_

CROSS OUT ANY  
AUTHORITY THAT  
YOU DO NOT WANT  
YOUR AGENT  
TO HAVE

PLACE INITIALS  
HERE ONLY IF YOU  
WANT TO  
AUTHORIZE YOUR  
AGENT TO REFUSE  
ARTIFICIAL  
NUTRITION OR  
HYDRATION

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

1. My agent does not have authority to refuse or withdraw informed consent to health care necessary to provide comfort care.
2. My agent does not have the authority to refuse or withdraw informed consent to health care if I am pregnant, if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to my life, or unless my attending physician and at least one other physician to a reasonable degree of medical certainty determines that the fetus would not be born alive.
3. My agent cannot order the withdrawal of life---sustaining treatment, including artificially or technologically supplied nutrition or hydration, unless I am in a terminal condition or in a permanently unconscious state and two physicians have determined that life---sustaining treatment would not or would no longer provide comfort to me or alleviate my pain.
4. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

GENERAL  
LIMITATIONS ON  
AGENT'S  
AUTHORITY



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**NOMINATION OF GUARDIAN**

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

I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship.

I understand that the court will honor my nominations except for good cause shown or disqualification.

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

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

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

\_\_\_\_\_

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order:

**Guardian of my person's** name and relationship: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

**Alternate guardian of my person's** name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone number(s): \_\_\_\_\_

INITIAL THE  
BLANKS TO  
NOMINATE YOUR  
AGENT AS  
GUARDIAN OF YOUR  
PERSON

OTHERWISE, WRITE  
IN THE GUARDIAN  
OF YOUR PERSON  
HERE

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

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

If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order:

**Guardian of my estate's** name and relationship: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

**Alternate guardian of my estate's** name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone number(s): \_\_\_\_\_

By placing my initials, signature, check or other mark in this box, I direct that bond be waived for guardian or successor **guardian of my estate**.

\_\_\_\_\_

If I do **not** make any mark on this line, it means that I expect the guardian or successor guardian of my estate to be bonded.

INITIAL THE  
BLANKS TO  
NOMINATE YOUR  
AGENT AS  
GUARDIAN OF YOUR  
ESTATE

OTHERWISE, WRITE  
IN THE GUARDIAN  
OF YOUR ESTATE  
HERE

INITIAL THE  
BLANKS TO DIRECT  
THAT BOND BE  
WAIVED FOR THE  
GUARDIAN OF YOUR  
ESTATE

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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.

**Enforcement by Agent.** My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

**Release of Agent's Personal Liability.** My agent will not be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests.

**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

CHECK THE  
APPROPRIATE BOX  
TO INDICATE  
WHETHER YOU  
HAVE COMPLETED A  
LIVING WILL

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**Signature of Principal**

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

I understand that I may file a copy of this Health Care Power of Attorney with the probate court for safekeeping.

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

I sign my name to this Health Care Power of Attorney

on \_\_\_\_\_, 20\_\_\_\_, at \_\_\_\_\_, Ohio.

---

Principal

**[Choose Witnesses OR a Notary Acknowledgment.]**

**WITNESSES**

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

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

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

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**WITNESS OR NOTARY ACKNOWLEDGEMENT**

[Choose One]

**Witnesses.**

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

Witness One

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dated: \_\_\_\_\_, 20\_\_\_\_\_

Witness Two

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dated: \_\_\_\_\_, 20\_\_\_\_\_

**Notary Acknowledgment.**

State of Ohio

County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned notary

public, personally appeared \_\_\_\_\_, principal of the above Health Care Power of Attorney, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

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

OR

A NOTARY PUBLIC  
MUST COMPLETE  
THIS SECTION

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Palliative Care  
Organization.  
2023 Revised.

**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 agent) 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 agent 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 agent 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 agent 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 agent has general authority to make health care decisions for you under this document, the agent 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

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

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(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 agent is not prohibited from doing so under (4) below, the agent 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 AGENT 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.

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(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 AGENT 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 AGENT 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 AGENT 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.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

**OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE  
– PAGE 17 OF 18**

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Additionally, when exercising authority to make health care decisions for you, the agent 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 agent by including them in this document or by making them known to the agent in another manner.

When acting pursuant to this document, the agent 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 agent 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 agent 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 agent 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. Finally, a person you designate as an agent may lose their authority to act as your agent if there is a civil or criminal protective order against them that names you as the alleged victim, or if the agent is your spouse and you are currently going through a divorce or legal separation at the time of your incapacity.

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 agent 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 agent 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.

THIS NOTICE IS  
INCLUDED IN THIS  
PRINTED FORM AS  
REQUIRED BY OHIO  
REVISED CODE  
§1337.17.

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Hospice and  
Palliative Care  
Organization.  
2023 Revised.

**OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE  
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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 agent, 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.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

Courtesy of CaringInfo  
[www.caringinfo.org](http://www.caringinfo.org), 800-658-8898

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2023 Revised.

**STATE OF OHIO LIVING  
WILL DECLARATION**

**Notice to Declarant**

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable **only to individuals in a terminal condition or a permanently unconscious state**. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration takes precedence over a Health Care Power of Attorney.

You should consider completing a new Living Will Declaration if your medical condition changes or if you later decide to complete a Health Care Power of Attorney. If you have both a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.

NOTICE

State of Ohio Living  
Will Declaration of

PRINT YOUR  
NAME AND DATE OF  
BIRTH

\_\_\_\_\_  
(Print Full Name)

\_\_\_\_\_  
(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my direction that my dying not be artificially prolonged.

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care.

DEFINITIONS

**Definitions**

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

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

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

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

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

**Declarant** means the person signing the Living Will Declaration.

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

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

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

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

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

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

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

DEFINITIONS

DEFINITIONS

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

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

**Terminal condition** means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

**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.

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

**Notifications.** [Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority [cross out any unused lines]:

First contact's name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Second contact's name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Third contact's name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

INSTRUCTIONS

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

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

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

Special Instructions.

**By placing my initials, signature, check or other mark on this line, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw, consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain.**

---

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



**ANATOMICAL GIFT (OPTIONAL)**

Upon my death, the following are my directions regarding donation of all or part of my body: In the hope that I may help others upon my death, I hereby give the following body parts: [Check all that apply.]

All organs, tissue and eyes for any purposes authorized by law.

OR

- |                                       |                                     |   |   |
|---------------------------------------|-------------------------------------|---|---|
| <input type="checkbox"/> Heart        | <input type="checkbox"/> Lungs      | <input type="checkbox"/> Liver (and associated vessels)   | <input type="checkbox"/> Pancreas/Islet Cells |
| <input type="checkbox"/> Small Bowel  | <input type="checkbox"/> Intestines | <input type="checkbox"/> Kidneys (and associated vessels) | <input type="checkbox"/> Eyes/Corneas         |
| <input type="checkbox"/> Heart Valves | <input type="checkbox"/> Bone       | <input type="checkbox"/> Tendons                          | <input type="checkbox"/> Ligaments            |
| <input type="checkbox"/> Veins        | <input type="checkbox"/> Fascia     | <input type="checkbox"/> Skin                             | <input type="checkbox"/> Nerves               |

For the following purposes authorized by law:

- All purposes  Transplantation  Therapy  Research  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.

CHECK THE APPROPRIATE BOXES IF YOU WISH TO MAKE AN ANATOMICAL GIFT

**SIGNATURE of DECLARANT**

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

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

I sign my name to this Living Will Declaration

on \_\_\_\_\_, 20 \_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

**[Choose Witnesses OR a Notary Acknowledgment.]**

**WITNESSES**

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

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

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

WITNESS OR NOTARY ACKNOWLEDGMENT

[Choose One]

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.

Witness 1

Signature: \_\_\_\_\_

Print \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dated: \_\_\_\_\_, 20\_\_\_\_\_

Witness 2

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Dated: \_\_\_\_\_, 20\_\_\_\_\_

**OR. if there are no witnesses.**

**NOTARY ACKNOWLEDGMENT**

State of Ohio  
County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned  
Notary

Public, personally appeared \_\_\_\_\_, declarant of  
the above Living Will Declaration, and who has acknowledged that (s)he executed  
the same for the purposes expressed therein. I attest that the declarant appears  
to be of sound mind and not under or subject to duress, fraud or undue influence.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

My Commission is Permanent: \_\_\_\_\_

Courtesy of CaringInfo  
www.caringinfo.org, 800-658-8898

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

OR

A NOTARY PUBLIC  
MUST COMPLETE  
THIS SECTION

**State of Ohio  
Donor Registry Enrollment Form  
Notice to Declarant**

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

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

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

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

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

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

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

## OHIO DONOR REGISTRY ENROLLMENT - PAGE 2 OF 2

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**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> HEART                           | <input type="checkbox"/> INTESTINES  |
| <input type="checkbox"/> LUNGS                           | <input type="checkbox"/> SMALL BOWEL |
| <input type="checkbox"/> LIVER (AND ASSOCIATED VESSELS)  |                                      |
| <input type="checkbox"/> KIDNEY (AND ASSOCIATED VESSELS) |                                      |
| <input type="checkbox"/> PANCREAS/ISLET CELLS            |                                      |

**TISSUES**

- |                                       |                                 |
|---------------------------------------|---------------------------------|
| <input type="checkbox"/> EYES/CORNEAS | <input type="checkbox"/> VEINS  |
| <input type="checkbox"/> HEART VALVES | <input type="checkbox"/> FASCIA |
| <input type="checkbox"/> BONE         | <input type="checkbox"/> SKIN   |
| <input type="checkbox"/> TENDONS      | <input type="checkbox"/> NERVES |
| <input type="checkbox"/> LIGAMENTS    |                                 |

**For the Following Purposes Authorized By Law:**

- ALL PURPOSES   
  TRANSPLANTATION   
  THERAPY   
  RESEARCH   
  EDUCATION

**OPTION 3**

Please take me out of the Ohio Donor Registry.

SIGNATURE OF DONOR REGISTRANT	DATE
X	

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