DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

Lifecare Directives, LLC
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Las Vegas, NV 89108
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Toll Free: (877) 559-0527

~ Lifecare Directives ~

Health Care Advance Directive

For

Ohio Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Health Care Advance Directive

For

Ohio Residents

Statutory Compliant
Advance Directive for
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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Health Care Advance Directive
For Ohio Residents

_____ _____
Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The Ohio state legislature has enacted statutes supporting the use of both a living will and a power of attorney for health care by the public. The following documents were designed to be in compliance with these statutes.

There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your Advance Directive is fully and properly filled out.

***Understanding Your Directive*:**

Your Ohio advance directive is written in two parts. To be valid, the documents must be witnessed by two qualified adults, or notarized. It is recommend that you do both to ensure that your wishes are fully honored and that no future questions of validity arise.

While it is best if you fill out the whole document, you may choose to complete only ***Section I*** (a living will), leaving only a Declaration of your values and wishes. Or you may complete only ***Section II*** (a power of attorney for health care), just naming someone to speak for you. However, completing only one section may leave your family and others either without sufficient evidence to support your wishes, or unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty. So, you are strongly encouraged to complete the entire directive.

To complete the document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

Once completed, you should distribute copies of your advance directives to important others in your life – family members, physicians, close friends, your attorney, etc – and make sure that a copy is placed in your medical records at any institution where you regularly receive medical care. In this way others will know of your wishes, and the document can be found when it is most needed.

SECTION I:
OHIO LIVING WILL DECLARATION
and Health Care Instructions
(Pursuant to ORC Title XXI, Ch. §2133.01-§2133.16)

1. Introduction. *The Ohio living will declaration was designed to assist those wishing to direct life-sustaining medical treatment in either a terminal or a permanently unconscious condition. The statutes define "**life-sustaining treatment**" as "any medical procedure, treatment, intervention, or other measure that...will serve principally to prolong the process of dying" (§2133.01-Q). It includes the administration of food and water by artificial means (i.e., tube feeding and hydration). A "**terminal condition**" as an "irreversible, incurable, and untreatable condition...[where] 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" (§2133.01-AA). "**Permanent unconsciousness**" is defined as a condition that includes "both of the following: 1) irreversible unawareness of one's being and environment; and, 2) total loss of cerebral cortical functioning, resulting in...no capacity to experience pain or suffering" (§2133.01-U).*

Intent to Complete or Not Complete a Living Will Declaration:

2. I have chosen <u>not</u> to complete a living will Declaration at this time, but I <u>do</u> want to complete a Power of Attorney for Health Care (*sign and skip to page 4*):

Signature: _____ Date: _____

OR,

3. I, _____, being of sound mind, do willfully and voluntarily direct that the instructions provided herein are to be recognized as my Ohio living will Declaration and evidence of my health care treatment wishes. These instructions should be used to guide to any agent, proxy, representative, surrogate, health care professional, family member, guardian, conservator, or other persons or entities providing, overseeing, or making medical decisions regarding my care in the event I am unable to make my wishes otherwise known.

Treatment Wishes in a Terminal Condition:

4. If I have been examined by my attending physician and one other physician, and both concur that I am in a terminal condition – which condition is expected to take my life within "a relatively short time" (on the order of six (6) months or less) if no life-sustaining treatments are used to artificially prolong my life – then my wishes regarding the use of life-sustaining treatment are as follows:

(*initial all that apply*)

_____ I am to be given no life-sustaining treatments, including CPR (cardiopulmonary resuscitation) or other medications or interventions, excepting only those that are needed to ensure my comfort.

_____ Any life-sustaining treatments currently being given to me are to be withdrawn, excepting only those that are needed to ensure my comfort.

_____ I am to be permitted to die naturally, and without any artificial or technologically imposed interventions that could otherwise prolong the dying process.

Treatment Wishes in a Permanently Unconscious Condition:

5. If I have been examined by my attending physician and one other physician, and both have found me to be in a permanently unconscious condition – which condition has been without change during the immediately preceding twelve (12) months – then my wishes regarding the use of life-sustaining treatment are as follows:

(*initial all that apply*)

_____ I am to be given no life-sustaining treatments, including CPR (cardiopulmonary resuscitation) or other life-sustaining medications or interventions, excepting only those needed to ensure my comfort. However, food and water shall continue to be given me through tubes or other technological means, unless I have indicated otherwise in the paragraph which follows.

_____ All life-sustaining treatments currently being given to me shall be withdrawn excepting only those needed to ensure my comfort, and food and water through tubes unless I have indicated otherwise in the paragraph which follows.

_____ I am to be permitted to die naturally, and without any artificial or technologically imposed interventions that could otherwise prolong the dying process.

6. **WITHDRAWAL OR REFUSAL OF NUTRITION AND HYDRATION WHEN IN A PERMANENTLY UNCONSCIOUS STATE**:

☐ _____ IF I HAVE MARKED THE PRECEDING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY PHYSICIAN IS HEREBY DIRECTED TO WITHHOLD OR WITHDRAW FOOD (NUTRITION) AND FLUIDS (HYDRATION) PROVIDED THROUGH TUBES OR IV LINES, OR BY ANY OTHER ARTIFICIAL, MECHANICAL, OR TECHNOLOGICAL MEANS – IF I AM IN A ***PERMANENTLY UNCONSCIOUS*** STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINES, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT THE USE OF THIS NUTRITION AND HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

7. **REGARDING THE COMFORT AND PAIN RELIEF QUALITIES OF FOOD AND FLUIDS BY TUBE OR IV LINES**:

☐ _____ IF I HAVE MARKED THE PRECEDING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY PHYSICIANS AND ANY OTHERS ARE DIRECTED TO PRESUME THAT THE USE OF NUTRITION AND HYDRATION ARE NOT NEEDED TO PROVIDE COMFORT OR ALLEVIATE MY PAIN, IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINES TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT ALTERNATE COMFORT OR PALLIATIVE CARE MEDICATIONS CAN BE USED TO ADEQUATELY RELIEVE MY PAIN AND/OR PROVIDE SUBSTITUTE COMFORT,

8. ***Anatomical Gift Declaration*** *(optional)*: I want my family and others to know that my wishes regarding organ and tissue donation are as follows:

For transplant purposes: (*please initial only <u>one</u>*)

_____ I <u>want</u> to donate any needed organs and tissues.
_____ I <u>want</u> to donate **only** those organs or tissues I have indicated here: _____.
_____ I am <u>undecided</u> about organ and tissue donation.
_____ I do <u>not</u> want to donate *any* organs or tissues.

If for research or education only:

(*please initial only <u>one</u>*)

_____ I <u>want</u> to donate organs and tissues, even if needed <u>only</u> for research or education.
_____ I am <u>undecided</u> about organ and tissue donation if used only for research or education.
_____ I do <u>not</u> want to donate organs or tissues if they will be used <u>only</u> for research or education.

9. ***Ohio Donor Registry Enrollment and Form*** (*optional*).

Ohio requires that a Donor Registry Enrollment form be included with any pre-printed advance directive document. It is found on page 15. You should indicate here that you have received and made a personal choice about the use of this enrollment form.

(*please initial only <u>one</u>*)

_____ I have completed the Ohio Donor Registry Enrollment Form.
_____ I have chosen not to complete the Ohio Donor Registry Enrollment Form.

10. ***Statutory Limitation***:

If I am pregnant and decisions must be made about life-sustaining treatment, I understand that life-sustaining treatment may not be withheld or withdrawn if the withholding or withdrawal of the treatment would terminate the pregnancy, unless it has been determined that the baby would not be viable (able to survive) at the time of birth even if life-sustaining treatments were continued.

11. ***Other Wishes, Desires and Directions*** (*optional*): _____

Personal Statement and Signature:

12. These directions express my legal right to accept or refuse treatment under the laws of Ohio. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

By signing below, I indicate that I am fully aware of the contents of this Document, and understand its full purpose, effect, and import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*Sign in the presence of <u>two</u> qualified witnesses; see below*)

Signed: _____

Date: _____

Address: _____

Statement and Signatures of Witnesses

I am at least 18 years of age. I know the principal personally, or I have been provided convincing evidence of identity. The principal has affixed (or caused to have affixed) his/her signature or mark in my presence. This document is being executed voluntarily, and the principal appears to be of sound mind and under no duress, fraud, or undue influence. I have not signed the principal's signature (above) for or at the direction of the principal. I am not the a health care representative, agent, surrogate or proxy, nor a successor of such in this directive document. I declare under penalty of perjury that I am not related to the principal by blood or marriage, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not the employee of a life or health insurance provider for the principal, and to the best of my knowledge I have no claim against nor am I entitled to any part of the individual's estate upon his or her death under a deed, will or codicil now existing, nor by any other operation of law.

Witness: _____

Printed Name:_____

Address: _____

Witness: _____

Printed Name:_____

Address: _____

SECTION II:
DURABLE POWER OF ATTORNEY FOR HEALTH CARE
And Declaration of Treatment Instructions

(Pursuant to Ohio Statutes, Title XIII §1337.01-1337.17)

1. Introduction *This section lets you name a person (an agent, or attorney-in-fact) to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. The powers intended to be granted through this document include the power to make health care decisions, as well as other authorities regarding related affairs. If you have questions, you should seek legal advice.*

Notice to Adult Executing this Document

(*Mandatory Ohio Preface*)

"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 car 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 are 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 for yourself, if you had the capacity to do so. The authority of the attorney-in-fact to make health care decisions for you ***generally*** will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

"***However***, even if the attorney-in-fact has general authority to make health care decisions for you under this document, the attorney-in-fact ***never*** will be authorized to do any of the following:

"1. Refuse or withdraw informed consent to life-sustaining treatment, ***unless*** your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

"(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness or injury from which (I) there can be no recovery, *and* (II) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, *and* your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

"(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment *and* by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, *and* your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

"2. Refuse or withdraw informed consent to health care necessary to provide you with comfort care (*except* that, if he or he 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 you 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 determines, 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,

"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 death is imminent and 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 of 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 lie (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.

"Additionally, when exercising his [or her] 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 him [or her] 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 if you so choose.

"Generally, you can designate any competent adult as the attorney-in-fact under this document. However, you ***cannot*** designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney-in-fact under this document. Additionally, you ***cannot*** designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney-in-fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

"This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care 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.

"If you execute this document and created 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."

Statement of Intent and Purpose:

2. Be it known that I:

   Full Legal Name: _____

   Date of Birth: _____

   Street Address: _____

   City: _____ County: _____

   State: _____ Zip Code: _____

   ~~ Intend by this document to create a durable power of attorney. I am of sound mind, and state that execution of this document is voluntary and without duress. This power of attorney shall not be affected by any future disability, incompetency, or incapacity of myself (the "principal" herein). Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical decisions for me if I become unable to make them for myself . It also grants my agent authority (to the extent allowed by law) to make related legal and personal care decisions as outlined in this document.

3. By creating this document I revoke any prior advance directive or power of attorney for health care. This designation is effective when I am no longer able make personal medical treatment decisions.

4. I understand that I am <u>not</u> required to choose an agent (attorney-in-fact), but that I am advised to do so to ensure that my wishes are fully represented and followed. Therefore:

   (*initial only <u>one</u>*)

   ____I do <u>not</u> want to choose a health care agent at this time (or I have no one appropriate to the task). However, I instruct that my wishes in Sections I of this document be

recognized to the fullest extent possible as a declaration of my wishes within this Advance Health Care Directive, and through this Durable Power of Attorney for Health Care (*initial above, and sign on page 12*);

***OR*,**

____ I do wish to appoint a health care agent. I recognize that the person I choose to appoint may *not* be my attending physician, nor the administrator of any nursing home in which I am receiving care, nor an employee or agent of my attending physician, nor an employee or agent of a health care facility at which I am being treated – unless either type of employee or agent is a competent adult and related to me by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and we are members of the same religious order. The person I have chosen to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself is:

5. **Name of Agent**: _____
   Address: _____
   Telephone: Home:_____ Work:_____
   Cell Phone or Pager: _____ E-mail: _____

6. If for any reason I revoke the authority of my agent, or this individual is unavailable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternate proxies:

7. **Name of Alternate #1:**_____
   Address: _____
   Telephone: Home:_____ Work:_____
   Cell Phone or Pager: _____ E-mail: _____

8. **Name of Alternate #2:** _____
   Address: _____
   Telephone: Home:_____ Work:_____
   Cell Phone or Pager: _____ E-mail: _____

9. Each alternate successor designated shall be vested with the same power and duties as if originally named as my health care agent. These persons, acting successively and *in priority of the order presented*, are to have binding authority over any and all other persons to make my personal health care decisions. In making decisions in my behalf *if my wishes are not already clear*, I direct my agent to act in his/her best understanding of what my wishes would have been. The authority of my agent shall not be terminated *unless* it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

10. **Nomination Guardian/Conservator**. I also nominate these persons, in priority of the order presented, to be appointed as my guardian and/or conservator , to serve without bond or security, should such legal appointment ever become necessary, *unless* I have nominated someone else, or revised the order of priority, here:

Name:_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

SPECIFIC AGENT AUTHORITIES AND GENERAL INTENT:

11. In accordance with my wishes, my agent and physicians are hereby authorized to do any and all of the following (to the extent allowed by law):

A) _____ *When in a Terminal Condition*: Consent, refuse consent, renew, withhold or withdraw informed consent to any and all life-sustaining treatments, *including the use of food (nutrition) and fluids (hydration) provided to me through tubes or IV lines, or by any other artificial, mechanical, or technological means*.

B) _____ *When in a Permanently Unconscious Condition*: Consent, refuse consent, renew, withhold or withdraw informed consent to any and all life-sustaining treatments. *However, my agent is not authorized to refuse, withdraw, or otherwise end the use of food (nutrition) and fluids (hydration) provided through tubes or IV lines, or by any other artificial, mechanical, or technological means unless I have specifically authorized this in the paragraph which follows*:

Required Tube Feeding and Hydration Statements:

The following statements, printed in "conspicuous" typeface, and with both "check-mark" and "initial" lines, address the content and format requirements necessary to refuse food and water by the use of non-natural means in specifically allowed health states.

12. WITHDRAWAL OR REFUSAL OF NUTRITION AND HYDRATION WHEN IN A PERMANENTLY UNCONSCIOUS STATE:

☐ _____ IF I HAVE MARKED THE PRECEDING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT IS HEREBY GRANTED THE AUTHORITY TO CONSENT, REFUSE CONSENT, RENEW OR WITHDRAW INFORMED CONSENT TO THE USE FOOD (NUTRITION) AND FLUIDS (HYDRATION) PROVIDED THROUGH TUBES OR IV LINES, OR BY ANY OTHER ARTIFICIAL, MECHANICAL, OR TECHNOLOGICAL MEANS – IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINES, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT THE USE OF THIS NUTRITION AND HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

13. REGARDING THE COMFORT AND PAIN RELIEF QUALITIES OF FOOD AND FLUIDS BY TUBE OR IV LINES:

☐ _____ IF I HAVE MARKED THE PRECEDING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT AND PHYSICIANS ARE DIRECTED TO PRESUME THAT THE USE OF NUTRITION AND HYDRATION ARE NOT NEEDED TO PROVIDE COMFORT OR ALLEVIATE MY PAIN ***IF*** MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINES, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT:

A) ALTERNATE COMFORT OR PALLIATIVE CARE MEDICATIONS CAN BE USED TO ADEQUATELY RELIEVE MY PAIN AND/OR PROVIDE SUBSTITUTE COMFORT, ***AND***

B) PROVIDED THIS DECISION IS MADE WHEN I AM IN A HEALTH STATE I HAVE ALREADY INDICATED I DID NOT WANT.

Further Clarification of Agent Authority:

If I have designated an agent to represent me in making medical decisions, I want others to know that his or her authority *specifically* includes the following:

(*mark the adjacent box and initial to authorize*)

14. ☐ _____MY AGENT IS SPECIFICALLY AUTHORIZED TO MAKE DECISIONS ABOUT WHETHER ARTIFICIAL FEEDING (TUBE FEEDING) AND HYDRATION (IV LINES PLACED IN MY VEINS TO GIVE ME WATER) CAN BE USED, LIMITED (E.G., FOR DELIVERY OF MEDICATIONS ONLY), WITHHELD OR WITHDRAWN IN ANY AND ALL SITUATIONS ALLOWED BY LAW OR OTHER RECOURSE.

15. *Additional Health Care-related Agent Authorities*:

(*initial the following if you wish to grant your agent this authority*):

_____ My agent is authorized to make all health-care decisions for me. THIS AUTHORIZATION INCLUDES THE AUTHORITY TO CONSENT TO THE PROVISION, WITHHOLDING OR WITHDRAWAL OF ANY LIFE-SUSTAINING TREATMENT OR PROCEDURE *EVEN* IF THE CONSENT OR REFUSAL OF SUCH WILL RESULT IN MY DEATH; **and** to legally act in *every* other matter related to my health care with that same authority I would have, without incurring any personal, legal or financial liability for such.

16. **When Agent's Authority Becomes Effective**: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions and shall not be affected by my disability or incompetence or lapse of time.

17. **Agent's Obligation**: My agent shall make health-care decisions for me in accordance with this power of attorney for health care and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

18. **Nomination of Guardian**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have

named, in the order designated. If my agent or one of my alternate agents is appointed as Guardian of my person, then I request that the Guardian shall act without the necessity of posting bond.

19. **Statement of Desires, Special Provisions, and Limitations**.
Noted below are any added limitations or other provisions which my health care agent must follow in acting in his or her representative capacity:

Other Desires: _____
_____
_____
_____
_____
_____
_____
_____
_____

STATEMENT AND SIGNATURE OF PRINCIPAL/GRANTOR:

20. This document is governed by Ohio law, although I request that it be honored in any state in which I may be found.

By signing below, I indicate that I am fully aware of all the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

21. Signed:_____ Date: _____

At: (City) _____ (State) _____

QUALIFIED WITNESSES

22. This Advance Directive for Health Care may not be upheld unless it is: (1) signed by two qualified adult witnesses who are personally present when you sign, or to whom you acknowledge (verbally confirm) your signature, ***OR*** (2) signed before a notary public. (*Lifecare staff recommend you do both*). If you choose to use witnesses rather than a notary public, they must qualify to sign the following statement:

Statement and Signatures of Witnesses:

23. I am at least 18 years of age. I know the principal personally, and believe him or her to be of sound mind, and that this document is being executed voluntarily. The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. I have not signed the principal's signature

for or at the direction of the principal. I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, nor am I directly responsible for his or her medical care or costs. Further, I am not the attending physician, nor an employee of the physician or other health care provider or current care facility, nor a party to any parent organization thereof. I am also not involved in directly physically caring for the individual, and to the best of my knowledge I am not entitled to any part of the individual's estate upon his or her death under a will now existing nor by any other operation of law.

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (*if you do not sign in the physical presence of two witness, your signature must be acknowledged (affirmed) before a notary to be valid (see §2133.02.B.2)*):

24. State of Ohio,

County of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**

Signature of Notary Public

_____

Date Commission Expires

PHOTOCOPIES AND FACSIMILES:

106. A photocopy (photostatic copy) or electronic facsimile ("fax") of this document shall be deemed as valid as the original. I understand I should keep the original copy, and give copies of the original to: 1) my agent and alternate agents, 2) my physician(s), 3) members of my family and others who might be called in the event of a medical emergency, and 4) any hospital or other health care facility where I receive treatment. My agent(s) any my family or friends should be directed to give a copy of this directive to my health care provider(s) or physician(s) upon request.

For additional copies of this directive, or other related materials, please contact:

Lifecare Directives, LLC, at:
5348 Vegas Drive – Las Vegas, NV 89108.
Telephone: (877) 559-0527
Website: www.lifecaredirectives.com

Ohio

Donor Registry

Enrollment Form:

To register for the Donor Registry, *photocopy or detach this page and <u>then</u> complete the form and send it to the Ohio Bureau of Motor Vehicles*. This form must be signed by two witnesses. If the donor is under age eighteen, one witness must be the donor's parent or legal guardian.

(*initial only one*)

____ Please include me in the Donor Registry.
____ Please remove me from the Donor Registry.

Full Name (printed): _____
Mailing Address: _____
Telephone: _____ Date of Birth: _____
Driver's Lic# _____ ID Card#: _____
Social Security# _____

On my death, I make an anatomical gift of the following specified organs, tissues, or eyes for any purposes indicated below.

____ Any purpose authorized by law.
____ Transplantation
____ Therapy
____ Research
____ Education
____ Advancement of Medical Science
____ Advancement of Dental Science
____ Other _____.

_____ _____
Signature of Donor Registrant Date

_____
Witness Signature

_____
Witness Signature