[The following sections appear if you choose to include your wishes for health care and medical decisions if you are incapacitated and unable to make them yourself.]

OHIO LIVING WILL DECLARATION

OF

Jane Doe

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I, Jane Doe, being of sound mind and disposing mind and memory, do hereby make and declare this to be my Living Will Declaration, revoking and making null and void any and all other living wills and health care directives previously made by me.

I. LIVING WILL

[This section will appear if you elect to be kept on life support.]

A. I voluntarily make known my desire to prolong my life as long as reasonably possible within the limits of generally accepted health care standards.

[This section will appear if you elect to not be kept on life support and will vary depending on your choices.]

A. If I have been diagnosed by two physicians that any of the following are true:

- I am in a terminal condition; that is, 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, there can be no recovery and death is likely to occur within a relatively short time if life-sustaining treatment is not administered;

_____
(Initial)

- I am permanently unconscious; that is, a state of permanent unconsciousness where, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards, there is irreversible unawareness of one's being and environment and total loss of cerebral cortical functioning, resulting in no capacity to experience pain or suffering; including, but not limited to being in a permanent coma or persistent vegetative state;

and I am no longer able to make decisions regarding my medical treatment, I willfully and voluntarily make known my desire not to be kept alive with artificial life support systems and direct my attending physician to withhold or withdraw treatment that only prolongs my life and is not necessary for my comfort or to alleviate pain.

_____ (initial)

B. IF I AM PERMANENTLY UNCONSCIOUS AND MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME, IT IS MY PREFERENCE **TO RECEIVE** ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION (FOOD AND FLUIDS).

C. If I am pregnant, and that fact is known to my physician, this Section I will have no force or effect during my pregnancy. However, if it is determined that it is not possible that the fetus could develop to the point of live birth with continued application of life-prolonging procedures, it is my preference that this document be given effect at the time of such determination.

D. I desire to receive treatment for comfort or to alleviate pain except: If it is addictive.

[This section will appear if you write additional health care instructions.]

E. I further direct that: Please make sure that I will not feel any pain.

[Section II varies depending upon your choices regarding organ donation.]

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_____ (Initial)

II. ANATOMICAL GIFTS

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

Gift: All organs and parts.
Purpose: Medical purposes, education, and research.

III. GENERAL PROVISIONS

A. If any provision hereof is held to be invalid, such invalidity shall not affect the other provisions of this document, and such other provisions will be given effect without the invalid provision.

B. It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

C. All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs for any damages or claims arising because of their actions or inactions based on this document. My estate will indemnify and hold them harmless.

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(Initial)

IN WITNESS WHEREOF, I have executed this document on the date below:

_____
Signature of Jane Doe

Dated: _____, 20___

100 Main Street
[CITY], Ohio [ZIP]

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_____
(Initial)

WITNESS DECLARATIONS

Under penalty of perjury, each of the undersigned declares that: (1) Jane Doe has been personally known to me (or that the individual's identity was proven to me by convincing evidence), and I believe him or her to be of sound mind and not under duress, fraud, or undue influence; (2) I did not sign Jane Doe's signature above, and Jane Doe signed or acknowledged this document in my presence; (3) I am not related to Jane Doe by blood, marriage, or adoption; (4) I am not entitled to any part of Jane Doe's estate or directly financially responsible for his or her medical care; (5) I am competent and at least eighteen years of age; (6) I am not Jane Doe's doctor or physician, or an employee of Jane Doe's doctor or physician; and (7) I am not the operator or an employee of a community care facility or a residential care facility for the elderly.

Signature:_____

Print Name:_____

Address:_____

_____

Signature:_____

Print Name:_____

Address:_____

_____

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DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)

OF

Jane Doe

INSTRUCTIONS: In addition to completing the references to Anatomical Gifts in your Living Will and Ohio Health Care Power of Attorney you may also complete and file the "Donor Registry Enrollment Form" with the Ohio Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organ and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Ohio Donor Registry and will be accessible only to the appropriate organ, tissue or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions.

To register for the Donor Registry, please complete this form, copy and send the original to:

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

Make a copy of this form and retain it as part of your Living Will Declaration.

This form must be signed by two witnesses.

If the donor is under age eighteen, one witness must be the donor's parent or legal guardian.

Please indicate below:

___ Please include me in the donor registry

___ Please remove me from the donor registry

Print or type full name of living donor _____

SAMPLE

Mailing Address _____
City_____ State_____ Zip_____
Phone ( ) _____ Date of Birth _____
Driver's License or ID Card Number _____
Social Security Number _____

___ On my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

OR

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

Gift: All organs and parts.
Purpose: Medical purposes, education, and research.

This form is signed and witnessed in accordance with Ohio Revised Code section 2108.05 (B)(1).

_____
Signature of Donor

Dated: _____, 20___

We hereby witness the signing of this Donor Registry Enrollment Form at the request of the donor.

_____
Witness

Dated: _____, 20___

_____
Witness

Dated: _____, 20_

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(Initial)

[The following sections appear if you choose to appoint someone to make health care decisions for you if you are unable to make them yourself.]

STATE OF OHIO
HEALTH CARE POWER OF ATTORNEY

Notice to Adult Executing This Document

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

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

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

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact **GENERALLY** will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you **GENERALLY** will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

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

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

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a. You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which

i. there can be no recovery and

ii. your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

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

2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);**

3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

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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.**
   b. **Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.**
   c. **If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:**
      i. **Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;**
      ii. **Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.**
   d. **Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the requirements of (4)(c)(i) and (ii) above.**

5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact **GENERALLY** will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

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(Initial)

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

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care 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 create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

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

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

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(Initial)

STATE OF OHIO
HEALTH CARE POWER OF ATTORNEY

OF

Jane Doe

I state that this is my Health Care Power of Attorney and I revoke any 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.

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I. APPOINTMENT OF HEALTH CARE AGENT

A. If it is determined that I am unable to provide express and informed consent to medical treatment and surgical and diagnostic procedures, I wish to designate as my agent for health care decisions:

Name: John Doe
Relation: Husband
Address: 100 Main Street
[CITY], Ohio [ZIP]
Phone: (800) 555-1234
Alt. Phone: (888) 123-5555
Email: jdoe@legalzoomsample.com

[This section appears if you choose to appoint an alternate agent.]

If my agent is unable or is unwilling to perform his or her duties, I designate as my alternate agent:

Name: Ann Doe
Relation: Daughter
Address: 100 Main Street
[CITY], Colorado [ZIP]
Phone: (800) 555-1234
Alt. Phone: (888) 123-5555
Email: adoe@legalzoomsample.com

_____
(Initial)

B. I fully understand and intend that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; to have access to my records necessary to make decisions or apply for benefits; and to authorize my admission to or transfer from a health care facility. I specifically give my agent the power and authority to provide, withdraw, or withhold consent to the provision of life-prolonging procedures on my behalf; and to execute all documents, waivers, and releases related to any of the foregoing and the powers set forth in the previous sentence. My agent must act consistently with my desires as outlined in my Living Will, if any.

_____ (initial) C. IF I AM PERMANENTLY UNCONSCIOUS AND MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME, IT IS MY PREFERENCE **TO RECEIVE** ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION (FOOD AND FLUIDS).

[The following section appears if you place limitations on your agent's authority.]

Notwithstanding the foregoing, the authority of my surrogate is limited as follows: I do not wish my agent to decide which organs to donate. I want as many as possible to be donated.

D I do not authorize my agent to direct the disposition of my remains.

E. I do not authorize my agent to consent to an autopsy of my remains.

[The following section appears if you choose to nominate someone to serve as your guardian. You can appoint an alternate guardian if your first choice is unavailable.]

II. <u>GUARDIAN APPOINTMENT</u>

[The following statement appears if you choose your agents to serve as your guardian.]

If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

SAMPLE

_____ (Initial)

[The following statement appears if you choose someone other than your agent to serve as your guardian.]

If a guardian of my person is to be appointed, I nominate the following person, each to act successively in the order named, to serve as my guardian.

Guardian
Name: Jack Doe
Relation: Son
Address 100 Main Street
[CITY], Ohio [ZIP]
Phone: (777) 777-7777
Alt. Phone: (888) 888-88880
Email: jackd@legalzoomsample.com

Alternate Guardian
Name: Mary Smith
Relation: Mother
Address 100 Main Street
[CITY], Ohio [ZIP]
Phone: (999) 999-9999
Alt. Phone: (111) 111-1111
Email: msmith@legalzoomsample.com

III. GENERAL PROVISIONS

A. If any provision of this Health Care Power of Attorney is held to be invalid, such invalidity will not affect the other provisions of this document, and such other provisions will be given effect without the invalid provision.

B. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state laws, and exclusively for the purpose of making a determination of my incapacitation or inability to direct my own health care decisions and obtaining a physician affidavit of such, I authorize any health care provider to disclose to the person named herein as my health care agent, alternate health care agent, or second alternate health care agent, as applicable, any pertinent individually identifiable health information sufficient to determine whether I am by reason of illness or mental or physical disability, incapacitated or incapable of directing my own health care decisions. In exercising such authority, my health care agent will constitute my "personal representative" as defined by HIPAA.

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(Initial)

Upon the determination of my incapacitation or incapability to direct my own health care decisions, I intend for the person named herein as my health care agent, alternate health care agent, or second alternate health care agent, as applicable, to be treated as my "personal representative" under HIPAA and any similar state laws, and as such to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records.

C. It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

D. All persons or entities that in good faith endeavor to carry out the provisions of this document will not be liable to me, my estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this document. My estate will indemnify and hold them harmless.

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(Initial)

SIGNATURE

IN WITNESS WHEREOF, I have signed this Health Care Power of Attorney on the date below.

_____
Signature Jane Doe

Dated: _____, 20____

100 Main Street
[CITY], Ohio [ZIP]

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_____
(Initial)

WITNESSES

Each of the undersigned attests that: Jane Doe signed or acknowledged this Health Care Power of Attorney in my presence; Jane Doe appears to be of sound mind and not under or subject to any duress, fraud, or undue influence; I am not an agent designated in this document; I am not the attending physician of Jane Doe; I am not the administrator of a nursing home in which Jane Doe is receiving care; and I am an adult not related to the Jane Doe by blood, marriage, or adoption.

Signature:_____

Print Name:_____

Address:_____

_____

Signature:_____

Print Name:_____

Address:_____

_____

legalzoom.com®
SAMPLE

_____
(Initial)