DEFINITIONS

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

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.

INSTRUCTIONS

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: _____

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

ADD OTHER INSTRUCTIONS OR LIMITATIONS, IF ANY, REGARDING YOUR ANATOMICAL GIFT PLANS

ATTACH ADDITIONAL PAGES IF NEEDED

Additional instructions or limitations.
[If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write "None" below.]

_____

_____

_____

_____

_____

_____

_____

_____

_____

[The "anatomical gift" language provided below is required by ORC §2133.07(C). Donate Life Ohio recommends that you indicate your authorization to be an organ, tissue or cornea donor at the Ohio Bureau of Motor Vehicles when receiving a driver license or, if you wish to place restrictions on your donation, on a Donor Registry Enrollment Form (attached) sent to the Ohio Bureau of Motor Vehicles.]

[If you use this living will to declare your authorization, indicate the organs and/or tissues you wish to donate and cross out any purposes for which you do not authorize your donation to be used. Please see the attached Donor Registry Enrollment Form for help in this regard. In all cases, let your family know your declared wishes for donation.]

ANATOMICAL GIFT (OPTIONAL)

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

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

☐ Heart	☐ Lungs	☐ Liver (and associated vessels)	☐ Pancreas/Islet Cells
☐ Small Bowel	☐ Intestines	☐ Kidneys (and associated vessels)	☐ Eyes/Corneas
☐ Heart Valves	☐ Bone	☐ Tendons	☐ Ligaments
☐ Veins	☐ Fascia	☐ Skin	☐ 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.

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

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.]

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.

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

Witness 1

Signature: _____

Print Name:

Address: _____

Dated: _____ , 20_____

Witness 2

Signature: _____

Print Name: _____

Address: _____

Dated: _____ , 20_____

OR

OR, if there are no witnesses,

NOTARY ACKNOWLEDGMENT

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned Notary

Public, personally appeared _____, 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
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800-658-8898

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

To register, please complete and mail this enrollment form to:
Ohio Bureau of Motor Vehicles
Attn: Records Request
P.O. BOX 16583
Columbus, OH 43216-6583

PLEASE PRINT

LAST NAME	FIRST	MIDDLE
MAILING ADDRESS		
CITY	STATE	ZIP
PHONE ( ) -	DATE OF BIRTH / /	STATE OF OHIO DL/ID CARD OR SSN

DONOR REGISTRY ENROLLMENT OPTIONS

OPTION 1

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

OPTION 2

☐ Upon my death, I make an anatomical gift of my organs, tissues and/or eyes selected below.

☐ ALL ORGANS, TISSUES AND EYES

ORGANS

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

TISSUES

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

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	

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

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

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

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

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

4. You may also want to save a copy of your form in 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.

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

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

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

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

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit www.NationalHospiceFoundation.org

You may wonder if a gift of $35, $50 or $100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$35	helps us provide webinars to hospice professionals
$50	helps us provide free advance directives
$100	helps us maintain our free InfoLine
$_____	to support the mission of the National Hospice Foundation.

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

2020AD

OR donate online today: www.NationalHospiceFoundation.org/donate