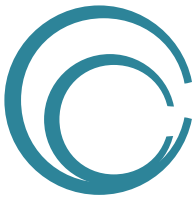

compassion & choices

Care & Choices at the End of Life.

Advance Directive

Planning for Important Healthcare Decisions

Ohio

State of Ohio Durable Power of Attorney for Healthcare

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 healthcare decisions for you if you lose the capacity to make informed healthcare decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed healthcare decisions for yourself and, not withstanding this document, as long as you have t he capacity to make informed healthcare decisions for yourself, you retain the right to make all medical and other healthcare decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make healthcare 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 healthcare matter, the attorney in fact GENERALLY will be authorized by this document to make healthcare 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 healthcare 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 healthcare 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

(Continued)

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 in formed healthcare 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 healthcare decisions for yourself);

(2) Refuse or withdraw informed consent to healthcare 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 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 UNCON-

(Continued)

SCIOUS 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.

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

(Continued)

Additionally, when exercising authority to make healthcare 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 healthcare, to review healthcare records, and to consent to the disclosure of healthcare records. You can limit that right in this document if you so choose.

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 healthcare 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 specifya date upon which your Durable Power of Attorney for Healthcare generally will expire. However, if you specify an expiration date and then lack the capacity to make informed healthcare 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 healthcare 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 healthcare 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 Healthcare with it, it will revoke any prior, valid durable power of attorney for healthcare that you created, unless you indicate otherwise in this document.

This document is not valid as a Durable Power of Attorney for Healthcare unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are

(Continued)

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.

OHIO DURABLE POWER OF ATTORNEY FOR HEALTHCARE

1. DESIGNATION OF attorney in fact.

I, _____, presently residing at
(name)

_____, Ohio,
(address)

intending to create a Durable Power of Attorney for Healthcare under Chapter 1337 of the Ohio Revised Code, do hereby designate and appoint:

_____ presently residing at
(name of agent)

_____
(address)

_____
(home telephone number) (work telephone number)

as my attorney in fact who shall act as my agent to make healthcare decisions for me as authorized in this document.

2. GENERAL STATEMENT OF AUTHORITY GRANTED. I hereby grant to my agent full power and authority to make all healthcare decisions for me to the same extent that I

(Continued)

could make such decisions for myself if I had the capacity to do so, at any time during which I do not have the capacity to make or communicate informed healthcare decisions for myself. My agent shall have the authority to give, to withdraw or to refuse to give informed consent to any medical or nursing procedure, treatment, intervention or other measure used to maintain, diagnose or treat my physical or mental condition. In exercising this authority, my agent shall make healthcare decisions that are consistent with my desires as stated in this document or otherwise made known to my agent by me or, if I have not made my desires known, that are, in the judgment of my agent, in my best interests.

3. ADDITIONAL AUTHORITIES OF AGENT. Where necessary or desirable to implement the healthcare decisions that my agent is authorized to make pursuant to this document, my agent has the power and authority to do any and all of the following:

(a) If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including the provision of artificially or technologically supplied nutrition or hydration;

(b) If I am in a permanently unconscious state, to give informed consent to life-sustaining treatment or to withdraw or to refuse to give informed consent to life-sustaining treatment; *provided, however, my agent is not authorized to refuse or direct the withdrawal of artificially or technologically supplied nutrition or hydration unless I have specifically authorized such refusal or withdrawal in Paragraph 4;*

(c) To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all of my medical and healthcare facility records;

(d) To execute on my behalf any releases or other documents that may be required in order to obtain this information;

(e) To consent to the further disclosure of this information if necessary;

(f) To select, employ, and discharge healthcare personnel, such as physicians, nurses, therapists and other medical professionals, including individuals and services providing home healthcare, as my agent shall determine to be appropriate;

(g) To select and contract with any medical or healthcare facility on my behalf, including, but not limited to, hospitals, nursing homes, assisted residence facilities, and the like; and

(Continued)

(h) To execute on my behalf any or all of the following:

(1) Documents that are written consents to medical treatment or written requests that I be transferred to another facility;

(2) Documents that are Do Not Resuscitate Orders, Discharge Orders or other similar orders; and

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

4. WITHDRAWAL OF NUTRITION AND HYDRATION WHEN IN A PERMANENTLY UNCONSCIOUS STATE.

☐ _____ IF I HAVE MARKED THE FOREGOING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT MAY REFUSE, OR IN THE EVENT TREATMENT HAS ALREADY COMMENCED, WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY SUPPLIED NUTRITION AND HYDRATION IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINES, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT SUCH NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

5. DESIGNATION OF ALTERNATE AGENT. Because I wish that an agent shall be available to exercise the authorities granted hereunder at all times, I further designate each of the following individuals to succeed to such authorities and to serve under this instrument, in the order named, if at any time the agent first named (or any alternate designee) is not readily available or is unwilling or unable to serve or to continue to serve:

First Alternate Agent: _____,
(name) (relationship)

presently residing at _____
(address)

_____
(home telephone number) (work telephone number)

(Continued)

Second Alternate Agent: _____,
(name) (relationship)

presently residing at _____
(address)

_____
(home telephone number) (work telephone number)

Each alternate shall have and exercise all of the authority conferred above.

6. NO EXPIRATION DATE. This Durable Power of Attorney for Health Care shall not be affected by my disability or by lapse of time. This Durable Power of Attorney for Healthcare shall have no expiration date.

7. SEVERABILITY. Any invalid or unenforceable power, authority or provision of this instrument shall not affect any other power, authority or provision or the appointment of my agent to make healthcare decisions.

8. PRIOR DESIGNATIONS REVOKED. I hereby revoke any prior Durable Powers of Attorney for Healthcare executed by me under Chapter 1337 of the Ohio Revised Code. I understand the purpose and effect of this document and sign my name to this Durable Power of Attorney for Healthcare after careful deliberation on

_____ at _____, Ohio.
(date) (city)

_____
(principal)

THIS DURABLE POWER OF ATTORNEY FOR HEALTHCARE WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY TWO ELIGIBLE WITNESSES AS DEFINED BELOW WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

(Continued)

I attest that the principal signed or acknowledged this Durable Power of Attorney for Healthcare in my presence, that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not the agent designated in this document, I am not the attending physician of the principal, I am not the administrator of a nursing home in which the principal is receiving care, and that I am an adult not related to the principal by blood, marriage or adoption.

Signature: _____

Print Name: _____

Residence Address:_____

Date: _____

Signature: _____

Print Name: _____

Residence Address:_____

Date: _____

OR

ACKNOWLEDGEMENT

State of Ohio

County of _____, s.s.:

On this the _____ day of _____, 20 _____,

before me, the undersigned Notary Public, personally appeared _____

_____, known to me or

(Continued)

satisfactorily proven to be the person whose name is subscribed to the above Durable Power of Attorney for Healthcare as the principal, and 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.

My Commission Expires:

_____

notary public

State of Ohio Living Will Declaration

NOTICE TO DECLARANT

This form of a Living Will Declaration is designed to serve as evidence of an individual's desire that life-sustaining medical treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if the individual is unable to communicate and is in a terminal condition or a permanently unconscious state.

If you would choose **not** to withhold or withdraw any or all forms of life-sustaining treatment, you have the legal right to so choose and you might want to state your medical treatment preferences in writing in another form of Declaration.

Under Ohio law a Living Will Declaration may be relied on only for individuals in a terminal condition or a permanently unconscious state. If you wish to direct your medical treatment in other circumstances, you should consider preparing a Durable Power of Attorney for Healthcare.

I, _____, presently residing at
(name)

_____, Ohio,
(address)

(the "Declarant"), being of sound mind and not subject to duress, fraud or undue influence, intending to create a Living Will Declaration under Chapter 2133 of the Ohio Revised Code, do voluntarily make known my desire that my dying shall not be artificially prolonged.

If I am unable to give directions regarding the use of life-sustaining t reatment when I am in a terminal condition or a permanently unconscious state, it is my intention that this Living Will Declaration shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment. **I am a competent adult who understands and accepts the consequences of such refusal and the purpose and effect of this document.**

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

- administer no life-sustaining treatment, including cardiopulmonary resuscitation;
- withdraw life-sustaining treatment, including cardiopulmonary resuscitation, if such treatment has commenced and in the case of cardiopulmonary resuscitation issue a do-not-resuscitate order; and,

(Continued)

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

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

- administer no life-sustaining treatment, including cardiopulmonary resuscitation, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal;
- withdraw such treatment, including cardiopulmonary resuscitation, if such treatment has commenced; and, in the case of cardiopulmonary resuscitation issue a do-not-resuscitate order;
- permit me to die naturally and provide me with only that care necessary to make me comfortable and to relieve my pain but not to postpone my death.

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

Other directions:

(Continued)

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, he or she shall make a good faith effort and use reasonable diligence to notify one of the persons named below in the following order of priority:

1. _____ (name), _____ (relationship)

presently residing at _____ (address)

_____
(home telephone number) (work telephone number)

2. _____ (name), _____ (relationship)

presently residing at _____ (address)

_____
(home telephone number) (work telephone number)

☐ I have a durable power of attorney for healthcare

For purposes of this Living Will Declaration:

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

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

(Continued)

(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.

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

(1) I am irreversably unaware of myself and my environment, and

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

I understand the purpose and effect of this document and sign my name to this Living Will Declaration after careful deliberation on

_____, at _____, Ohio.
(date) (city)

_____
(declarant)

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. I further attest that I am not the attending physician of the Declarant, I am not the administrator of a nursing home in which the Declarant is receiving care, and that I am an adult not related to the Declarant by blood, marriage, or adoption.

1. Signature: _____

Print Name: _____

Residence Address : _____

Date: _____

(Continued)

2. Signature: _____

Print Name: _____

Residence Address : _____

Date: _____

OR

ACKNOWLEDGEMENT

State of Ohio

County of _____, SS:

On this the _____ day of _____, 20 _____,

before me, the undersigned Notary Public, personally appeared_____ _____, known to me or satisfactorily p roven to be the Declarant whose name is subscribed to the above Living Will Declaration, and 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.

My Commission Expires:

_____
(notary public)

P. O. Box 101810
Denver, CO 80250

tel 800.247.7421
fax 866.312.2690