**Caution:** The following sample Ohio living will declaration form is approved by the Ohio State Bar Association and used by the Franklin County Recorder's Office. To be effective, this or any similar form **must** be recorded in the Ohio resident's county of residence. Those wishing to complete an Ohio living will should, therefore, consult their county recorder's office for more specific details as to how to proceed.

# State of Ohio

## Living Will Declaration

## Notice to Declarant

*Provided by*


# ROBERT G. MONTGOMERY

**Franklin County Recorder**

**373 South High Street, 18th Floor Columbus OH 43215**

**(614) 462-3930, FAX (614) 462-4299**


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life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state.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

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

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

You should consider completing a new Living Will Declaration if your medical condition changes, or if you later decide to complete a Health Care Power of Attorney If you have both documents, you should keep copies of both documents together, with your other important papers, and bring copies of both your Living Will and your Health Care Power of Attorney with you whenever you are a patient in a health care facility.

# State of Ohio

## Living Will Declaration

## Of

_____

(Print Full Name)

_____

(Birth Date)

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

If I am unable to give directions regarding the use of life-sustaining treatment when I am in a terminal condition or a permanently unconscious state, I intend that this Living Will Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

***Definitions.*** Several legal and medical terms are used in this document. For convenience they are explained below.

***Artificially or technologically supplied nutrition or hydration*** means the providing of food and fluids through intravenous or rube "feedings".

***Cardiopulmonary resuscitation*** or ***CPR*** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

***Declarant*** means the person signing this document.

***Do Not Resuscitate*** or ***DNR Order*** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

***Health care*** means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

***Health Care Power of Attorney*** means another document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

***Life-sustaining treatment*** means any health care including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

***Living Will Declaration*** or ***Living Will*** means this document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

***Permanently unconscious state*** means an irreversible condition in which I am permanently unaware of myself and my surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

***Terminal condition*** or ***terminal illness*** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

*[Instructions and other information to assist in completing this document are set forth within brackets and in italic type]*

***Health Care if l Am in a Terminal Condition.*** If I am in a terminal condition and unable to make my own health care decisions, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR and artificially or technologically supplied nutrition or hydration; and

2. Withdraw such treatment, including CPR, if such treatment has started; and

3. Issue a DNR Order; and

4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

***Health Care if l Am in a Permanently Unconscious State.*** If I am in a permanently unconscious state, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal; and

2. Withdraw such treatment, including CPR, if such treatment has started; and

3. Issue a DNR Order; and

4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

***Special Instructions.*** **By placing my initials at number 3 below, I want to specifically authorize my physician to withhold or to withdraw artificially or technologically supplied nutrition or hydration if:**

1. **I am in a permanently unconscious state; and**

2. **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; and**

3. **I have placed my initials on this line: _____**

*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:

*[Note: If you do not name two contacts, you may wish to cross out the unused lines.]*

| First Contact: | Second Contact: |
|---|---|
| Name: _____ | Name: _____ |
| Address:_____ | Address: _____ |
| _____ | _____ |
| Telephone: _____ | Telephone: _____ |

***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.

***Health Care Power of Attorney.*** **I** have completed a Health Care Power of Attorney:
_____ Yes _____No

***SIGNATURE***
*[See below for witness or notary requirements.]*

I understand the purpose and effect of this document and sign my name to this Living Will Declaration on _____. 20_____ at _____. Ohio.

_____
DECLARANT

*[You are responsible for telling members of your family, the agent named in your Health Care Power of Attorney (j [you have one), and your physician about this document. You also may wish to tell your religious advisor and your lawyer that you have signed a Living Will Declaration. You may wish to give a copy to each person notified.]*

*[You may choose to file a copy of this Living Will Declaration with your County Recorder for safekeeping.]*

***WITNESSES OR NOTARY ACKNOWLEDGMENT***
*[Choose one.]*

*[This Living Will Declaration will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature,* ***or*** *it is acknowledged before a Notary Public.]*

*[The following persons* ***cannot*** *serve as a witness to this Living Will Declaration: the agent or any successor agent named in your Health Care Power o f Attorney; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician: or if you are in a nursing home, the administrator of the nursing home.]*

***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. I further attest that I am not an agent designated in the Declarant's Health Care Power of Attorney, 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 I am an adult not related to the Declarant by blood, marriage or adoption.

_____residing at _____
Signature

_____ _____
Print Name

Dated: _____, 20_____

_____residing at _____
Signature

_____
Print Name

Dated: _____, 20

***OR***

***Notary Acknowledgment***
State of Ohio
County of _____ss.

On _____20_____before me, the undersigned Notary Public, personally appeared _____ known to me or satisfactorily proven to be the person whose name is subscribed to the above Living Will Declaration as the Declarant, 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: _____

**The following is an enlarged version of the pocket-sized ID card you will receive when your recorded document is returned to you. To avoid any inadvertent errors in interpreting your designated options, please <u>checkmark and initial</u> each of the items that pertain to your desired instructions. <u>Sign your name on the "Declarant" line</u>. We will then produce your wallet card accordingly.**

***Provided by***

# <u>ROBERT G. MONTGOMERY</u>

Franklin County Recorder

----------Enlarged Pocket Sized ID Card----------

## <u>ATTENTION MEDICS</u>

***The following documents are filed with the:***

**Franklin County Recorder's Office**

**373 South High Street, 18th Floor Columbus OH 43215**
**(614) 462-3930, FAX (614) 462-4299**

_____Living Will _____Healthcare Power of Attorney _____Do Not Resuscitate

Declarant: _____

Instrument Number: _____