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.

Anatomical Gift means a donation of all or part of a human body to take effect upon or after death.

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

Donor Registry Enrollment Form means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

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 I 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 I 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:
Name: _____

_____

Address: _____

Second Contact:
Name:

Address:_____

_____

_____

Telephone:_____ Telephone:

_____

Anatomical Gift (optional)

INSTRUCTIONS: If you elect to make an anatomical gift, please complete and file the attached "Donor Registry Enrollment Form" with the Ohio Bureau of Motor Vehicles to ensure that your wishes will be honored.

____ I wish to make an anatomical gift.

____ I *do not* 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, _____ (name of donor), may help others upon my death, I hereby give the following body parts:
_____ (indicate specific parts or all body parts) for any purpose authorized by law: transplantation, therapy, research or education. *[Cross out any purpose that is unacceptable to you.]*

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

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.

Donor Registry Enrollment Form. I have completed the Donor Registry Enrollment Form.

_____Yes_____No

NOTE: If you modify or revoke your decision regarding anatomical gifts, please remember
to make those changes in your Living Will, Health Care Power of Attorney, and Donor Registry
Enrollment Form.

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 (if 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 of 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:

_____

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.