

# State of Ohio

## Living Will Declaration

### Notice to Declarant

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life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state.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, a 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 takes precedence 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 a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.]*



# Ohio Living Will Declaration

[R.C. §2133]

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(Full Name)

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(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations 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.

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 direction that my dying not be artificially prolonged. [R.C. §2133.02 (A)(1)]

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care. [R.C. §2133.03(B)(2)]

## Definitions

**Adult** means a person who is 18 years of age or older.

**Agent or attorney-in-fact** means a competent adult who a person (the “principal”) can name in a Health Care Power of Attorney to make health care decisions for the principal.

**Anatomical gift** means a donation of part or all of a human body to take effect after the donor’s death for the purpose of transplantation, therapy, research or education.

**Artificially or technologically supplied nutrition or hydration** means food and fluids provided through intravenous or tube feedings. *[You can refuse or discontinue a feeding tube, or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]*

**Comfort care** means any measure, medical or nursing procedure, treatment or intervention, including nutrition and or hydration, that is taken to diminish a patient’s pain or discomfort, but not to postpone death.

**CPR** means cardiopulmonary resuscitation, one of several ways to start a person’s breathing or heartbeat once either has stopped. It does not include clearing a person’s airway for a reason other than resuscitation.

**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.

**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 declarant's attending physician and one other physician who has examined the declarant, 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.

**No Expiration Date.** This Living Will Declaration will have no expiration date. However, I may revoke it at any time. [R.C. §2133.04(A)]

**Copies the Same as Original.** Any person may rely on a copy of this document. [R.C. §2133.02(C)]

**Out of State Application.** I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §2133.14]

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]*: [R.C. §2133.05(2)(a)]

|                        |   |
|------------------------|---|
| X out area if not used | First contact's name and relationship: _____  |
|                        | Address: _____                                |
|                        | Telephone number(s): _____                    |
|                        | Second contact's name and relationship: _____ |
|                        | Address: _____                                |
|                        | Telephone number(s): _____                    |
|                        | Third contact's name and relationship: _____  |
|                        | Address: _____                                |
|                        | Telephone number(s): _____                    |

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 in this box, 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. [R.C. §2133.02(A)(3) and R.C. §2133.08]

**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)**

In the hope that I may help others upon my death, I hereby give the following body parts for the following purposes: *[Complete both sections.]*

Section 1. Body Parts. Check "All organs, tissue and eyes" or all that apply below that box.

All organs, tissue and eyes. If you check this box, do not check any other boxes in Section 1 and proceed to Section 2.

- |                                       |                                     |   |   |
|---------------------------------------|-------------------------------------|---|---|
| <input type="checkbox"/> Heart        | <input type="checkbox"/> Lungs      | <input type="checkbox"/> Liver (and associated vessels)   | <input type="checkbox"/> Pancreas/Islet Cells |
| <input type="checkbox"/> Small Bowel  | <input type="checkbox"/> Intestines | <input type="checkbox"/> Kidneys (and associated vessels) | <input type="checkbox"/> Eyes/Corneas         |
| <input type="checkbox"/> Heart Valves | <input type="checkbox"/> Bone       | <input type="checkbox"/> Tendons                          | <input type="checkbox"/> Ligaments            |
| <input type="checkbox"/> Veins        | <input type="checkbox"/> Fascia     | <input type="checkbox"/> Skin                             | <input type="checkbox"/> Nerves               |

Section 2. Purposes. Check "All purposes" or all that apply below that box.

All Purposes. If you check this box, do not check any boxes below.

- Transplantation    Therapy    Research    Education

If I do not indicate a desire to donate all or some of my body parts by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

**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. [R.C. §2133.02]

I sign my name to this Living Will Declaration

on \_\_\_\_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
Declarant

**[Choose Witnesses OR a Notary Acknowledgment.]**

**WITNESSES** [R.C. §2133.02(B)(1)]

*[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.]

***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.***

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Witness One's Signature                      Witness One's Printed Name                      Date

\_\_\_\_\_  
 Witness One's Address

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Witness Two's Signature                      Witness Two's Printed Name                      Date

\_\_\_\_\_  
 Witness Two's Address

**OR, if there are no witnesses,**

**NOTARY ACKNOWLEDGMENT [R.C. §2133.02(B)(2)]**

State of Ohio

County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 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:

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