

OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Ohio Revised Code 1337.11 to 1337.17)

The following Notice to Adult Executing This Document (Durable Power of Attorney for Health Care) is required by Ohio Revised Code, Section 1337.17. If, after reading this notice, you still have questions concerning the effect and legal consequences of executing this document, you should speak with a qualified attorney.

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** health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself. You may include specific limitations in this document on the authority of the attorney in fact to make health care 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 health care matter, the attorney in fact **GENERALLY** will be authorized by this document to make health care 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 health care 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 health care 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 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 informed health care 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 health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he 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 health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) 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 UNCONSCIOUS 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 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 ABOVE.

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

Additionally, when exercising his authority to make health care 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 him 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 health care, to review health care records, and to consent to the disclosure of health care 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 health care 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 specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care 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 health care 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 health care 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 health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are 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."

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

(Name of individual you choose as agent)

(Address; City; State; Zip Code)

(Home phone; Work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

(Name of individual you choose as first alternate agent)

(Address; City; State; Zip Code)

(Home phone; Work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

(Name of individual you choose as second alternate agent)

(Address; City; State; Zip Code)

(Home phone; Work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me. BY PLACING MY INITIALS IN THIS SPACE (_____), I SPECIFICALLY AUTHORIZE MY AGENT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO ME IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN. Any limitations on my agent's authority are listed here:

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions and shall not be affected by my disability or incompetence or lapse of time.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated. If my agent or one of my alternate agents is appointed as Guardian of my person, then I request that the Guardian shall act without the necessity of posting bond.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

_____ (a) Choice Not To Prolong Life

I do not want my life to be prolonged **if my physician, with the concurrence of two (2) other physicians** believes, (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become permanently unconscious, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

_____ (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. **If I mark this box , artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).**

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that: _____

PART 3

PRIMARY PHYSICIAN

(OPTIONAL)

(10) I designate the following physician as my primary physician:

(Name of Physician)

(Address; City; State; Zip Code)

(Phone)

(11) EFFECT OF COPY: A copy of this form has the same effect as the original.

(12) SIGNATURES: Sign and date the form here:

Date: _____

Signature _____

Printed Name _____

Address _____

City, State, Zip _____

THIS DECLARATION MUST BE WITNESSED BY TWO PERSONS AS SET OUT BELOW OR ACKNOWLEDGED BY THE DECLARANT BEFORE A NOTARY PUBLIC.

I hereby state that the Declarant, _____, signed the above declaration in my presence and that I am not related to the declarant by blood, marriage, or adoption, I am not the attending physician of the Declarant and I am not the administrator of a nursing home where the Declarant is receiving care. The Declarant appeared to me to be of sound mind and not under or subject to duress, fraud, or undue influence.

Witness:

Witness:

STATE OF OHIO

COUNTY OF _____

Personally appeared before me, a Notary Public in and for the County and State above named,

_____,
personally known to me or who proved his/her identity to my satisfaction, who acknowledged that he/she signed the above and foregoing Durable Power of Attorney of Health Care. Further, the Declarant appeared to me to be of sound mind and not under or subject to duress, fraud, or undue influence.

This is the _____ day of _____, 20_____.

Notary Public

My Commission expires: _____