DECLARATION CONCERNING THE USE OF LIFE SUSTAINING TREATMENT

(Ohio Revised Code Chapter 2133)

"I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by extraordinary means or by artificial nutrition or hydration if my condition is determined to be terminal or if I am diagnosed as being in a permanent unconscious state state. In making this Declaration, I understand the statutory definitions of the following terms:

"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 MY ATTENDING PHYSICIAN AND ONE OTHER PHYSICIAN WHO HAS EXAMINED ME, BOTH OF THE FOLLOWING APPLY: (1) THERE CAN BE NO RECOVERY. (2) MY DEATH IS LIKELY TO OCCUR WITHIN A RELATIVELY SHORT TIME IF LIFE-SUSTAINING TREATMENT IS NOT ADMINISTERED.

"PERMANENTLY UNCONSCIOUS STATE" MEANS THAT I AM IN A STATE OF PERMANENT UNCONSCIOUSNESS 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) IRREVERSIBLE UNAWARENESS OF MY BEING AND ENVIRONMENT. (2) TOTAL LOSS OF CEREBRAL CORTICAL FUNCTIONING, RESULTING IN MY HAVING NO CAPACITY TO EXPERIENCE PAIN OR SUFFERING.

With those definitions in mind, I am aware and understand that this writing authorizes my attending physician to withhold or discontinue extraordinary means or artificial nutrition or hydration, in accordance with my specifications set forth below:

(Initial any of the following, as desired):

(_____) If my condition is determined to be terminal, I authorize the following:

(_____) My physician may withhold or discontinue extraordinary means only.

(_____) In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

(_____)If my physician determines that I am in a permanently unconscious state, I authorize the following:

(_____) My physician may withhold or discontinue extraordinary means only.

(_____) In addition to withholding or discontinuing extraordinary means if such means are necessary, my physician may withhold or discontinue either artificial nutrition or hydration, or both.

ANATOMICAL GIFT (optional)

Upon my death, the following are my directions regarding donation of all or part of my body:

1. In the hope that I may help others upon my death, I hereby give the following body parts:

_____

_____

for any purpose authorized by law: transplantation, therapy, research, or education.

2. 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."

3. To register for the Ohio Donor Registry, use the following link to the OH Bureau of Motor Vehicles: http://publicsafety.ohio.gov/links/bmv3346.pdf

Date: _____

_____

Signature of Declarant

_____

Type or Print Name of Declarant

_____

Street Address

_____

City, State and Zip Code

THIS DECLARATION MUST BE WITNESSED BY TWO PERSONS AS SET OUT BELOW <u>OR</u> 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
_____	_____
Print or Type Name	Print or Type Name

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 Declaration Concerning the Use of Life Sustaining Treatment. 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: _____