ADVANCE DIRECTIVE AND HEALTH CARE POWER OF ATTORNEY, ADDENDUMS, AND INSTRUCTIONS

ENDORSED BY:

Greater Columbus Right to Life
Growing a Community of Life

Foundation for Life

Miami County Right to Life

Champaign County Right to Life

This is a document-only version of the Faithful at the End of Life Advance and Health Care Power of Attorney. It contains the instructions, HCPOA form, and addendums only. You may wish to consider the appropriate version of Optional Documents (Section 7 in the full program). Additional versions and full program content for *Faithful at the End of Life: Pro-Life Advance Medical Directives* and *Faithful at the End of Life: Pro-Life Advance Medical Directives, Catholic Edition*, can be obtained www.faithfulattheendoflife.org. This version contains two versions of the pocket card; please feel free to use the one that is appropriate if you would like.

This program and its materials are provided to the community as a service of Greater Columbus Right to Life and our partner and endorsing organizations. It has undergone extensive technical and legal review to ensure that it complies with Ohio law as of the date of its publication (October 1, 2020), but users are advised that it will be updated from time to time as changes are made to Ohio law or as is useful or necessary.

Ohio law permits an individual to adopt advance medical directives without the assistance of a lawyer, and you can use the enclosed forms and instructions in the same way that you can utilize other "standard forms" provided by bar associations, health care facilities, and similar organizations. However, these are important legal documents and you may wish to consult an attorney for advice. Neither Greater Columbus Right to Life nor any of our partner or endorsing organizations can provide you with legal advice, and we make no guarantees and assume no liability for the content.

IN CASE OF EMERGENCY

My name is: _____

My faith/church is: _____.
I have a protective HCPOA. My agent is: _____ and can be reached at _____. My alternate agent is_____ and can be reached at_____. Please contact my agent(s) and a chaplain. More contact information may be on the reverse.

IN CASE OF EMERGENCY

My name is: _____

I am a Roman Catholic and I have a protective HCPOA. My agent is: _____ and can be reached at _____. My alternate agent is_____ and can be reached at_____. Please contact my agent(s) and a Catholic Priest or review info on the reverse for more emergency contacts or instructions.

INSTRUCTIONS

The attached form is a legal document. You should read through these instructions and the form to be sure that you understand it prior to signing it. You may sign it with or without the assistance of an attorney, but if you have any questions you should seek the assistance of an attorney.

If you choose to sign this document without the assistance of an attorney, your signature must be witnessed by two adults who are eligible witnesses or by a notary public. The following **cannot** serve as witnesses:

- the person you name as your agent,
- the guardian of your person or estate (if you have one),
- any alternate or successor agent or guardian (if you have one),
- anyone related to you by blood, marriage, or adoption,
- your attending physician, or
- the administrator of any nursing home where you are receiving care.

At the end of the form, we have provided several addendums that you may opt to include. If you opt to include an addendum, please only select one option per topic.

Definitions[1]

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.

Attending physician means the physician to whom a principal or the family of a principal has assigned primary responsibility for the treatment or care of the principal or, if the responsibility has not been assigned, the physician who has accepted that responsibility.

Brain death means that, if neurological criteria are used to determine death, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem) must be clearly determined according to commonly held scientific means.[2]

[1] Unless otherwise noted, these definitions are from Chapter 1337 of the Ohio Revised Code.
[2] The Ohio Revised Code does not define "brain death" per se, although the definition of death found at Ohio Revised Code Section 2108.40 does state that an individual is dead if the individual has sustained "irreversible cessation of all functions of the brain, including the brain stem."

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.[3]

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.[4]

Guardian means a person appointed by a probate court pursuant to Chapter 2111 of the Revised Code to have the care and management of the person of an incompetent or his/her estate.

Health care means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition or physical or mental health.

Health care decision means informed consent, refusal to give informed consent, or withdrawal of informed consent to health care.

Health care facility means any of the following: a hospital, hospice care program, pediatric respite care program, or other institution that specializes in comfort care of patients in a terminal condition or permanently unconscious state, a nursing home, a home health agency, an intermediate care facility for individuals with intellectual disabilities, or a regulated community mental health organization.

Health care personnel means physicians, nurses, physician assistants, emergency medical technicians-basic, emergency medical technicians-intermediate, emergency medical technicians-paramedic, medical technicians, dietitians, other authorized persons acting under the direction of an attending physician, and administrators of health care facilities.

Permanently unconscious state means a state of permanent unconsciousness in a principal[5] that, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by the principal's attending physician and one other physician who has examined the principal, is characterized by both irreversible unawareness of one's being and environment and total loss of cerebral cortical functioning, resulting in the principal having no capacity to experience pain or suffering.

Physician means a person who is authorized under Chapter 4731 of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

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

Ward means the person the court has determined to be incompetent. The ward's person, financial estate, or both, is protected by a guardian the court appoints and oversees.

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[3] See Ohio Health Care Power of Attorney, Definitions Section, page one, available at: www.ohiobar.org.
[4] Ibid, see also, Ohio Revised Code Section 2133.21.
[5] The Ohio Revised Code uses the term "principal." Principal is simply another word for the person/patient.

DIRECTIONS

Turn to Section Five: *Advance Directive and Health Care Power of Attorney*. The main form is seventeen pages long. Please read through each page and provide the information requested. You should also write or type your name in the space provided at the bottom of each page.

Page One:

- Print or type your full legal name and date of birth.
- Name your agent, the person who will make health care decisions for you. Your agent can be anyone you select.
- If you want to authorize your agent to obtain otherwise protected health care information, select this box. Selecting this box will authorize your agent to see past and future health care information to make decisions about your care.

Page Two:

- If your agent is unable or unwilling to make decisions for you, you can name an alternate agent or agents. If you wish to name those agents, please provide their names and contact information. ***We recommend that you do this***.

Page Nine:

- We have provided a list of optional addendums for you to sign with this document. Please check the boxes for any addendum that you have signed. Note that in some circumstances you may sign *either* "Option 1" or "Option 2." ***Only sign one of the options for each topic.***
- Addendum are identified as A-1 through A-8 of this document. *You do not have to sign any of these addendums.* Failing to sign any of the addendums will not prevent your agent from making a decision on those topics for you. However, if you sign one or more of the addendums, your agent will be obligated to follow your specific wishes.

Page Ten:

- Once you have read the entire document, you may sign and date the document in front of either your attorney, two witnesses that meet the standards described on page one of these instructions, or a notary public.

Pages Eleven and Twelve

- Pages 11 and 12 are for signature witnesses.

Page Thirteen

- You should use this space to share the names of individuals or places where original signed copies of this form are. You can also use it to insert the name of your attorney if the document was provided by an attorney.
- Make your wishes known to your family members, your medical care providers, and your other advisors. Let them know that you executed this document and give each agent a copy.

Pages Fifteen through Seventeen

- This is language that is required by the State of Ohio. Not all provisions may apply to this *Advance Directive and Health Care Power of Attorney*.

ADDENDUM

If you would like to sign an addendum as noted on page nine, the following applies to the addendums. There are eight pages of addendum options, paginated A-1 through A-8. If you have previously consented to organ donation and you have amended or revoked that consent, you may also wish to attach a copy of your amended or revoked consent. However, note that your amended or revoked consent must be made directly by 1) verbally revoking or amending at the BMV, 2) amending or revoking consent online at www.donatelifeohio.org, or 3) mailing in the form found online at that same website.

Page A-1
Instructions to honor my pro-life beliefs and Christian Faith. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

Page A-2
If you are a woman of child-bearing age, you may wish to review this addendum. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

Pages A-3 and A-4
If you would like to nominate a Guardian of the Person, you may use one of these documents to nominate a guardian, should guardianship proceedings be started, for your person. *If you wish to sign one of these addendums, please sign and date the page for the option you chose and check the appropriate box on Page 9.*

Page A-5
If you would like to nominate a Guardian of the Estate, you may wish to sign this page. Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

Page A-6
If you have not completed a Living Will, you should check that box to make it clear that you have not. If you have previously signed a Living Will, you may check "yes" to specify that you would like to revoke the prior Living Will. *If you wish to sign this addendum, please sign and date the page and check the appropriate box on Page 9.*

Pages A-7 and A-8
You may sign either option if you wish to make specific provisions regarding organ donation. *If you wish to sign one of these addendums, please sign and date the page for the option you chose and check the appropriate box on Page 9.*
Note on Addendums: Failing to sign any of the addendums will not prevent your agent from making a decision on those topics for you. However, if you sign one or more of the addendums, your agent will have more information and will be better able to follow your specific wishes.

OPTIONAL DOCUMENTS AND ADDITIONAL FORMS

In addition, we have included several optional forms/checklists/resources that you may find helpful. None of these are part of the *Advance Directive and Health Care Power of Attorney,* but they may be useful to you, your agent, and your family. You may use these forms or create your own. **NOTE: Optional documents are specialized for faith tradition and are not in this packet. To select the optional documents, visit www.faithfulattheendoflife.org and make the appropriate selection.**

Page O-1
This is an optional letter to your agent. You may use this letter or draft your own letter. It is not a legally binding document, but it may help your agent to better understand some of your decisions and will help express your beliefs.

Page O-2
This is a listing of your spiritual and religious needs. It includes information that may be helpful, especially if your agent does not share your faith background.

Pages O-3 through O-5
This is additional information that may be helpful, including your church, your preferred burial arrangements, and information on people or resources that may be helpful. It is important to note that once you are no longer alive, the agent under a Health Care Power of Attorney will no longer have authority to make decisions on your behalf. At that time, decision making will fall to your next of kin, beneficiaries, executor of your estate, etc. This information can be helpful for your agent and loved ones so that they know who will be responsible for making funeral plans and who is the executor of your estate (if you have one).

Please remember that none of these optional forms are legal documents; they are merely tools that can help to guide your agent and your loved ones in decision-making. If you wish to establish legally binding requirements on your kin or estate after your death, you should contact your legal advisor and consider including this as part of your will or other estate documents. For example, some people may wish to require a Mass of Christian Burial as part of their estate planning.

Notes

State of Ohio

ADVANCE DIRECTIVE AND HEALTH CARE POWER OF ATTORNEY

_____

(Print Full Name)

_____

(Birth Date)

This is my Advance Directive and Health Care Power of Attorney. I revoke all prior advance directives for health care and health care proxies, including Living Wills and Health Care Powers of Attorney signed by me. I further revoke my consent to any prior DNR order, POLST (Physician Orders for Life-Sustaining Treatment), MOLST (Medical Orders for Life Sustaining Treatment), or similar order. 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 understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

NAMING OF MY AGENT AND ALTERNATE AGENT(S)

The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name and relationship: _____

Address: _____

Telephone number(s): _____

☐ **By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to obtain my protected health care information immediately and at any future time.**

Guidance to Agent. My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, my agent will determine my best interests after considering the benefits, the burdens and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Naming of alternate agent(s). If my agent named above is unable or unwilling to make decisions for me, then I name, in the following order of priority, the persons listed below as my alternate agents (cross out any unused lines):

First Alternate Agent's name and relationship:_____

Address: _____

Telephone number(s): _____

Second Alternate Agent's name and relationship:_____

Address: _____

Telephone number(s): _____

Each alternate shall have and exercise all of the authority conferred in this Advance Directive and Health Care Power of Attorney. Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

A future separation, dissolution, divorce, or annulment of my marriage (or the filing for any of the aforementioned items) will revoke the selection of my current spouse as my health care agent. See, also, R.C. 1337.30(B)(3). Similarly, if my agent is subject to any type of protection order in which I am the alleged victim, he/she will not be competent to serve as my agent under this document. See R.C. 1337.13(H).

AUTHORITY OF AGENT

I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make those decisions for myself if I had the ability to do so.

The power and authority granted to my agent in this document is effective only if I am unable to give informed consent with respect to health care decisions, and only for the duration of my inability to make such decisions.

In exercising this authority, my attorney in fact shall make health care decisions that are consistent with my desires as stated in this document or in matters not addressed by my instructions in this document, as otherwise known to my agent. My agent shall be guided by my medical diagnosis and prognosis and any information provided by my physicians as to the intrusiveness, pain, risks, side effects, benefits and alternatives associated with treatment or non-treatment. My agent shall not authorize a course of treatment which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing.

The provisions of this Health Care Power of Attorney apply to any diagnosis, whether I am in a terminal condition, a permanently unconscious state, or otherwise.

These provisions are effective during any period of time in which I am unable to communicate my informed consent because of illness or injury.

Where necessary or desirable to implement the health care decisions that my agent is authorized to make pursuant to this document, my agent has the power and authority to do any and all of the following:

1. To make decisions for me with respect to any health care procedure (including surgery), consent to care, treatment, interventions, or other measure, including palliative care. Any decisions of my health care agent shall be subject to the provisions and limitations expressed in this document.

2. To request, review, and receive any information, verbal or written, regarding my physical or mental condition, including, but not limited to, all of my medical and health care facility records. I expressly give my agent the authority to review, copy and utilize my medical and health care facility records for purposes of HIPAA. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

3. My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

4. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.

5. To execute on my behalf any releases or other documents that may be required in order to obtain medical and related information.

6. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any person who acts while relying on this Advance Directive and Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

7. To select, employ, and discharge health care personnel, such as physicians, nurses, therapists and other medical professionals, including individuals and services providing home health care, as my agent shall determine to be appropriate.

8. To select, contract for my admission to, transfer me to or authorize my discharge from any medical or health care facility on my behalf, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

9. To apply for Medicare, Medicaid, or other programs or insurance benefits for me. My agent can see my personal files, like bank records, to find out what is needed to fill out these forms.

10. My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger.

11. To visit me in any institution to which I have been transported for emergency care, observation, or admitted for inpatient or outpatient health care, and to authorize visitation subject to physician orders and policies of the institution to which I have been transported or admitted. Institution shall include, but not be limited to, a hospital, skilled nursing facility, hospice or other health care facility.

12. To transport me or arrange for my transportation to a place where this Advance Directive and Health Care Power of Attorney is honored, if I am in a place where the terms of this document are not enforced.

13. To execute on my behalf any or all of the following:

    a. Documents that are written consents to medical treatment, or other similar orders;
    b. Documents giving or withholding consent for a Do Not Resuscitate (DNR) order;
    c. Documents that are written requests that I be transferred to another facility, written requests to be discharged against medical advice, or other similar requests; and
    d. Any other document necessary or desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

INSTRUCTIONS FOR HEALTH CARE DECISIONS

I direct my health care provider(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, or reduce or prevent the deterioration in, any physical or mental condition. Nothing is to be done or omitted with the intent to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery;

all to the full extent necessary to correct, reverse, or alleviate life-threatening or health-impairing conditions, or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

The instructions in this designation are intended to be followed even if it is alleged that I attempted suicide after I signed this designation.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age, physical or mental disability, or the actual or anticipated "quality" of my life. I direct that my life not be ended by assisted suicide or euthanasia, the latter meaning any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) to follow the above policy, even if I am judged to be incompetent.

During the time in which I have lost the capacity to make informed decisions for myself, my agent, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, including in the following situations.

When My Death is Imminent

If I have an incurable terminal illness or injury, and I will die imminently - meaning that at least two reasonably prudent physicians, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me - the following may be withheld or withdrawn:

- cardiopulmonary resuscitation (CPR);
- surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer; and
- a treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me.

When I am Terminally Ill

If I have an incurable terminal illness or injury and, even though death is not imminent, I am in the final stage of that terminal condition (meaning that at least two reasonably prudent physicians, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me) the following may be withheld or withdrawn:

- surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer, and
- a treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me.

However, treatment should not be withdrawn if my health care agent judges there are special and significant reasons why it should continue.

Providing me with Food and Fluids (Nutrition and Hydration)

I believe that food and water are not medical treatment nor medical procedures, but basic necessities which should be provided to me regardless of my physical or mental condition. I direct that food and fluids (nutrition and hydration) be provided to me orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

If my death is truly imminent; or I am unable to assimilate foods and fluids; or if there is some other serious medical problem preventing nourishment; or food or fluids endanger my condition; then the medically assisted supply of nutrition and hydration may be considered unnecessary and discontinued. The meaning of the words "imminent" and "unnecessary" for the purpose of this instruction are those which I have discussed with my agent.

Providing me with Pain Relief/Medication

Adequate efforts should be taken to relieve my pain though I do not want to be overmedicated to the point where I am unable to comprehend my situation and communicate with those around me. If my condition includes physical pain, I wish to receive pain-relieving medication in dosages sufficient to manage the pain. If I am dying and pain management should require increasingly greater dosages of medication, I direct that they be increased in increments sufficient to manage the pain, even if this increase should hasten my death. I know that I may morally receive medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life. Although pain relief may be necessary, it should never be intended to cause death by suppression of breathing or terminal sedation. Pain medication should not be given to me for the purpose of hastening my death.

LIMITATIONS OF AUTHORITY FOR AGENT AND OTHERS.

I have discussed my principles and beliefs with my agent. I trust my agent to make appropriate health care decisions on my behalf based upon past and future discussions, subject only to the limitations, provisions, and directions expressed in this document.

1. I clearly intend that, if I am unable to make health care decisions, my agent or alternate agents, if any, will make health care decisions for me. I expressly eliminate any authority of a health care provider or any agent or employee of a health care provider, ethics committee, or insurance company to seek removal or replacement of my agent.

2. I should not be deprived of consciousness without a compelling reason.

3. I direct that my life not be ended by doctor-prescribed suicide, assisted suicide or euthanasia, the latter meaning an action or omission that would directly and intentionally cause my death. I oppose suicide and euthanasia. Treatment or support must not be provided or withheld for the purpose of causing my death.

4. I do not wish to be treated by any health care provider or health care facility which permits, prescribes, provides, or promotes assisted suicide (via prescription or device or

other means) unless emergency treatment is necessary and no other health care provider/health care facility is reasonably available.

5. I *do not authorize* any treatments that are derived from any tissue, organ or other substance from an unborn, newborn or stillborn child, including but not limited to embryonic stem cells. However, this prohibition does not apply a) if such are derived from an ectopic pregnancy, or b) to vaccines my agent deems appropriate, or to c) any other treatment that my agent deems appropriate and is not the proximate cause of the death of any child.

6. I also reject any treatments that use an organ or tissue of another person, unless reasonable efforts have been made to ensure that the procurement of such organ or tissue did not cause, contribute to, or hasten that person's death.

7. My agent shall not have the authority to make decisions for me, or sign documents on my behalf that are inconsistent with the terms of this Advance Directive and Health Care Power of Attorney.

8. Definition of "brain death" for the purposes of making decisions for my care:
While either cardio-respiratory signs or neurological criteria may be used to determine my death, if neurological criteria are used, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem) must be clearly determined according to commonly held scientific means.

NOMINATION OF GUARDIAN. I nominate the person serving as my health care agent to serve as my guardian if one is needed, unless I have designated a different individual in one of the "Guardian of the Person" addendums (See A-3 and/or A-4)

NO EXPIRATION DATE. This Advance Directive and Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time. This Advance Directive and Health Care Power of Attorney is valid unless revoked.

ENFORCEMENT BY AGENT AND FINANCIAL RESPONSIBILITY. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document. I direct my agent to use the power and authority granted in this document to ensure (by taking legal action if necessary) that my rights are protected. My agent shall not be liable for the costs of treatment pursuant to my agent's authorization, based solely on that authorization.

RELEASE OF AGENT'S PERSONAL LIABILITY. My agent will not be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests. (R.C. Section 1337.35)

Note: This document does not confer immunity on, nor release, any physician or health care institution from liability.

PROTECTION FROM LIABILITY FOR PEOPLE RELYING ON THIS DOCUMENT. No person who may act in reliance upon the representations of my agent for the scope of authority granted to the agent shall incur any liability as to me or to my estate as a result of permitting the agent to exercise this authority, nor is any such person who deals with my agent responsible to determine or ensure the proper application of funds or property.

INTERPRETING THE TERMS IN THIS DOCUMENT. I have discussed the meanings of the words used in this Advance Directive and Health Care Power of Attorney with my agent, and my agent's interpretation of them is definitive.

INVALIDITY AND SEVERABILITY. To the extent my Advance Directive and Health Care Power of Attorney shall not be enforceable, these provisions are to be honored as the further expression of my intent. I deny the authority of any person or entity to treat or care for me, in a manner inconsistent with my Advance Directive and Health Care Power of Attorney. **Any invalid or unenforceable power, authority or provision of this instrument shall not affect any other power, authority or provision or the appointment of my agent to make health care decisions for me.**

SUBSEQUENT ADVANCE DIRECTIVES AND MEDICAL ORDERS. In the event that I execute another advance directive or give consent to a DNR order, POLST (Physician Orders for Life-Sustaining Treatment), MOLST (Medical Orders for Life Sustaining Treatment), or similar order at a later date and have not explicitly revoked this advance directive and health care power of attorney, I direct that this advance directive and health care power of attorney shall take precedence to the extent that any such additional directive, order, or consent conflicts with my wishes as expressed to my agent or as stated in this advance directive and health care power of attorney.

COPIES AND ORIGINALS. Any person may rely on a copy of this document [R.C. Section 1337.26(D)]

OUT OF STATE APPLICATION. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. Section 1337.26(C).

OHIO NOTICE. Ohio law requires that I be given the notice printed at the end of this document. I have read this notice before signing this.

Addendums

By checking boxes below, I indicate my intention to include those provisions in my Advance Directive and Health Care Power of Attorney, and those items are hereby incorporated by reference. If a box is not checked, that provision is not to be included in my Advance Directive and Health Care Power of Attorney.

☐ Instructions to honor my pro-life beliefs and my faith

☐ Additional Health Care Instructions for a woman of child-bearing age

☐ Guardian of the Person provision – Option 1

☐ Guardian of the Person provision – Option 2

☐ Guardian of the Estate provision

☐ Note on Living Will

☐ Organ donation – Option 1

☐ Organ donation – Option 2

SIGNATURE OF PRINCIPAL

I understand that I am responsible for telling members of my family and my physician, my lawyer, my religious advisor and others about this Health Care Power of Attorney. I understand I may give copies of this Health Care Power of Attorney to any person.

I understand that I may file a copy of this Advance Directive and Health Care Power of Attorney with the probate court for safekeeping. [R.C. Section 1337.12(E)(3)]

I understand that I must sign this Advance Directive and Health Care Power of Attorney and state the date of my signing, and that my signing either must be witnessed by two adults who are eligible to witness my signing OR the signing must be acknowledged before a notary public. [R.C. Section 1337.12]

I sign my name to this Advance Directive and Health Care Power of Attorney on

_____20___, at _____, Ohio.

_____
Principal

[Choose Witnesses or a Notary Acknowledgment.]

WITNESSES [R.C. Section 1337.12(B)]

[The following persons CANNOT serve as a witness to this Health Care Power of Attorney:

- *Your agent, if any;*
- *The guardian of your person or estate, if any;*
- *Any alternate or successor 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 any nursing home where you are receiving care.]*

I attest that the principal signed or acknowledged this Advance Directive and Health Care Power of Attorney in my presence, and that the principal 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

NOTARY ACKNOWLEDGEMENT

State of Ohio)
) ss:
County of _____)

On _____, before me, the undersigned notary public, personally appeared,

_____, principal of the above Advance Directive and Health Care Power of Attorney, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal 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: ☐

**NOTE: You should make your wishes known to your family members, your medical care providers and your other advisors. Original signature documents should be provided to the agents listed herein, and might also be given to your physician, your health care facility, and possibly others. Be sure to keep a distribution list so you can notify all holders of copies if you revoke your document.*

Original signed copies of this document have been provided to:

_____

_____

_____

_____

_____

_____

This document was prepared by: ***Insert name, address, and phone number of attorney if an attorney prepared this document.***

_____

_____

_____

_____

_____

The "Notice to Adult Executing this Document" that follows on the next page is required by Ohio law for any printed durable power of attorney for health care that is sold or otherwise distributed in the State of Ohio for use by adults *who are not advised by an attorney*.

Some of the explanation in this notice may not pertain to the *State of Ohio Advance Directive and Health Care Power of Attorney* since it is more life-affirming than durable powers of attorney for health care that are typically used in the State of Ohio. This notice has been included simply to comport with Ohio law. In addition, the copyright date "March 2015" pertains to the "Notice to Adult Executing this Document" section only: not the *State of Ohio Advance Directive and Health Care Power of 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, the 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 to 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 of (4)(c)(i) and (ii) 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.

ADDENDUM

This notice was not updated when certain provisions of the law regarding the Health Care Power of Attorney were changed in March 2014. Please be advised of the following changes:

You may, but are not required to, authorize your agent to get your health information, including information that is protected by law and otherwise not available to your agent. You can authorize your agent to have access to your health information immediately upon your signing of this document or at any later time, even though you are still able to make your own health care decisions.

You may also, but are not required to, use this document to name guardians for you or your estate should guardianship proceedings be started.

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ADDENDUMS

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INSTRUCTIONS TO HONOR MY PRO-LIFE BELIEFS AND MY CHRISTIAN FAITH

I strongly believe in pro-life principles and I do not agree with "Living Wills" and other similar directives biased in favor of death. I do not want any action taken that would directly cause or hasten my death. I believe that euthanasia is the deliberate act of taking the life of another, whether by active intervention or by omitting an action with the intention of causing death. I believe that euthanasia constitutes an unwarranted destruction of human life and is never morally permissible. I also believe that suicide (and assisted suicide) are never morally permissible.

Accordingly, this *Advance Directive and Health Care Power of Attorney* is to be interpreted in favor of continued life. I am a competent adult who understands and accepts the consequences, purposes and effects of this document. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. I direct that those caring for me avoid doing anything which is contrary to my pro-life beliefs. I wish to follow the moral teachings of my Church and to receive all the obligatory care that my faith teaches we have a duty to accept. However, I also know that death need not be resisted by any and every means and that I have the right to refuse medical treatment that is excessively burdensome to me.

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, with the faith teaching expressed in the documents listed in this *Advance Directive and Health Care Power of Attorney*, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my circumstances and treatment options. If action is taken to reduce treatment or care, please contact a pastor, priest, or other appropriate minister if at all possible.

_____ _____

Signature Date

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ADDITIONAL HEALTH CARE INSTRUCTIONS FOR A WOMAN OF CHILD-BEARING AGE

If I am pregnant, I direct that, regardless of my physical or mental condition, all medically indicated procedures, including medically assisted nutrition and hydration, be provided to sustain my life and the life of my unborn child until birth or at least until the child's viability is attained. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead[1] if there is a chance that doing so might allow my child to be born alive. No one is authorized to consent to any treatment or procedure for me whose sole immediate and directly intended effect is the termination of my pregnancy before the viability of my unborn child is attained.

I understand that I may morally accept or refuse operations, medications and forms of treatment that have as their direct purpose the cure of a serious pathological condition when these interventions cannot be safely postponed until the viability of my unborn child is attained, even if such interventions indirectly result in the death of my child.

_____ _____

Signature Date

[1] See definitions section for the definition of brain death for the purposes of this *Advance Directive and Health Care Power of Attorney*

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GUARDIAN OF THE PERSON PROVISION – OPTION 1

Nomination of Guardian
[R.C. Section 1337.28(A) and R.C. Section 2111.121]
[You may, but are not required to, use this document to nominate a guardian, should guardianship proceedings be started, for your person or your estate.]

- I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship. [R.C. Section 2111.121(C)]
- I understand that the court will honor my nominations except for good cause shown or disqualification. [R.C. Section 2111.121(B)]
- I understand that, if a **guardian of the person** is appointed for me, such guardian's duties would include making day-to-day decisions of a personal nature on my behalf, such as food, clothing, and living arrangements, but this or any subsequent Health Care Power of Attorney would remain in effect and control health care decisions for me, unless determined otherwise by the court. The court will determine limits, suspend, or terminate this or any subsequent Health Care Power of Attorney, if they find that the limitation, suspension, or termination is in my best interests. [R.C. Section 1337.28(C)].

I intend that the authority given to my agent in my Health Care Power of Attorney will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate the person(s) below in the order listed as **guardian of my person.**

	By writing my initials, signature, a check mark or other mark in this box, I nominate my agent and alternate agent(s), if any to be **guardian of my person**, in the order named above.

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order [cross out any unused lines]:

	Guardian of my person's name and relationship: _____

Address: _____

Telephone number(s): _____

Alternate guardian of my person's name and relationship: _____

Address: _____

Telephone number(s): _____

_____ _____
Signature Date

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GUARDIAN OF THE PERSON PROVISION – OPTION 2

(A) _____(Initials) I nominate the person serving as my health care agent to serve as my guardian.

OR

(B) _____(Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

_____

Telephone Numbers: _____

_____
(Home, Work, and Mobile)

_____ _____
Signature Date

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GUARDIAN OF THE ESTATE

GUARDIAN OF THE ESTATE
Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. The guardian of the estate is required to be bonded, unless bond is waived in writing or the court finds it unnecessary.

☐ By placing my initials, signature, check or other mark in this box, I nominate my agent or alternate agent(s), if any, as **guardian of my estate**, in the order named above.

*If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order [cross out any unused lines]:*

☐ *Guardian of my estate and relationship:* _____

Address: _____

Telephone number(s): _____

Alternate guardian of my estate and relationship: _____

Address: _____

Telephone number(s): _____

☐ By placing my initials, signature, check or other mark in this box, I direct that bond be waived for guardian or successor guardian of my estate. [R.C. Section 1337.28(B)]

*If I do **not** make any mark in this box, it means that I expect the guardian or successor guardian of my estate to be bonded. [R.C. 1337.28 (B)]*

_____ _____
Signature Date

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NOTE ON LIVING WILL

I have completed a Living Will: Yes ☐ No ☐

I hereby revoke any prior Living Will Yes ☐

_____ _____

Signature Date

Recommendations: If an individual has not signed a living will, the "no" box should be checked to make that clear.

If an individual previously signed a living will, the second "yes" box should be checked to make clear the individual's intention to revoke the living will.

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ORGAN DONATION – OPTION 1

I do not want to be an organ donor.

_____ _____

Signature Date

Please note: If you have previously consented to be listed on Ohio's organ donor registry and would like to amend or revoke that consent, there are three ways that your consent can be amended or revoked. They are 1) verbally indicate at the BMV when renewing your license, 2) amend or revoke your registration online at wwwdonatelifeohio.org, or 3) print out a copy of the consent/amend/revoke form and mail it to the listed address. It is important that you take this additional step to ensure that your intentions will be legally honored/enforced.

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ORGAN DONATION – OPTION 2

Upon my death (*please initial one*):

_____ I do not wish to give my body or any organ.
_____ I wish to give my body.
_____ I wish to give any needed organs, tissues, or parts.
_____ I wish to give only non-vital organs
_____ I wish to give only the following organs, tissues, or parts:

_____

_____

_____

_____

No ovum or sperm shall be extracted – from my anatomical gift, from my organ or tissue donation, or as a tissue donation – for the purpose of creating an embryo.

Donated tissues or organs are not to be removed until it has been medically determined that I have died. In order to prevent any conflict of interest, the physician who determines my death should not be a member of the transplant team. While either cardio-respiratory signs or neurological criteria may be used to determine my death, if neurological criteria are used, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem) must be clearly determined according to commonly held scientific means.

My gift is to be used for the following purposes (*please initial the choices you desire*):

_____ Any purpose authorized by law that does not violate the teachings of my faith
_____ Transplantation
_____ Therapy
_____ Research
_____ Medical Education

My body or any remaining parts or organs not used are to be treated with respect and charity, because of my faith and hope in the Resurrection of the Dead. Proper Christian burial of my body or cremains, and reverent disposition of other remains should be provided.

_____ _____
Signature Date

Please note: If you have previously consented to be listed on Ohio's organ donor registry and would like to amend or revoke that consent, there are three ways that your consent can be amended or revoked. They are 1) verbally indicate at the BMV when renewing your license, 2) amend or revoke your registration online at wwwdonatelifeohio.org, or 3) print out a copy of the consent/amend/revoke form and mail it to the listed address. It is important that you take this additional step to ensure that your intentions will be legally honored/enforced.

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