Ohio's
Living Will

What you should know about Living Wills:

A **Living Will** is a document that allows you to establish, in advance, the type of medical care you would want to receive if you were to become permanently unconscious, or if you were to become terminally ill and unable to tell your physician or family what kind of life-sustaining treatments you want to receive. In addition, the latest edition of the Living Will allows you to specify your wishes regarding anatomical gifts (organ and tissue donation).

- A **Living Will** is used only in situations where you are unable to tell your physician what kind of health care services you want to receive. Before your **Living Will** goes into effect, you either must be:

  (1) terminally ill (see definition as described in the Living Will Declaration Form) and unable to tell your physician your wishes regarding health-care services;

  OR

  (2) permanently unconscious. To be considered permanently unconscious, two physicians (one of whom must be a medical specialist in an appropriate field) must decide that you have no reasonable possibility of regaining consciousness.

Regardless of your condition, if you were able to speak and tell your physician your wishes about life-prolonging treatments, then the **Living Will** wouldn't be used – your physician would just talk directly with you about your wishes. A **Living Will** is used by the physician only if you are unable to tell him or her what you want to be done.

- A **Living Will** gives your physician the authority to withhold all life-sustaining treatment and permit you to die naturally and take no action to postpone your death, providing you with only that care necessary to make you comfortable and relieve your pain. This may include writing a DNR Order or withdrawing life-sustaining treatment such as CPR.

  Such "comfort care" also may include removing nutrition and hydration (food and water) that is administered through feeding tubes or intravenously. If you wish to give your physician this authority if you become permanently unconscious, there is a space on the **Living Will** form that you must initial. If you want nutrition and hydration to be continued, regardless of the circumstances, don't initial this space.

- A **Living Will** can be honored only if your attending physician and others know about it. It is important to let your physician and your family and friends know that you have a **Living Will** before you become ill. After all, a **Living Will** can't be enforced if people don't know that it exists. In fact, it is a good idea for you to give your attending physician a copy of your **Living Will**. It also is important to give copies to family and friends so that, if necessary, they can advise your physician that you have a **Living Will**. In addition, it is important that you notify a health care facility that you have a **Living Will** when you are admitted as a patient. Please note: You **do not** have to go to court to put your **Living Will** into effect.

- Once the decision to withhold life-sustaining treatment is made, your physician must make a reasonable effort to notify the person or persons you designate in your **Living Will** or your closest family member.

- The law allows your family members to challenge a physician's determination that you have a terminal illness or that you are in a permanently unconscious state. This challenge is limited in nature and may be made only by your closest relatives. The law does not, however, allow your family members to challenge your own legally-documented decision not to be resuscitated.

- If you have both a **Living Will** and a **Health Care Power of Attorney,** the physician must comply with the wishes you state in your **Living Will**. In other words, your **Living Will** takes precedence over your **Health Care Power of Attorney**. There is a space on the **Living Will** form that you may check to let your physician and family and friends know that you have a **Health Care Power of Attorney**.

- You can revoke your **Living Will** at any time. You can do this by simply telling your physician and family that you have changed your mind and wish to revoke your **Living Will**. It is a good idea to ask anyone who has a copy of the document to return it to you.

How to fill out the Living Will form:

You should use this form to let your physician and your family know what kind of life-sustaining treatments you want to receive if you become terminally ill or permanently unconscious and are unable to express your wishes.

NOTE:

1. Read over all information carefully. Definitions are included as part of the form.

2. On the first two lines of the form, print your full name and birth date.

3. On the fourth page of the form, written in bold type face under ***Special Instructions*** is the statement that will give your physician permission to withhold food and fluids in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials on the line indicated in number 3.

4. The next section of the form (immediately below the ***Special Instructions***) provides space for you to list the names, addresses and phone numbers of the contacts (usually family members and close friends) that you want your physician to notify when the **Living Will** goes into effect. **Remember, the Living Will goes into effect only when you are terminally ill or permanently unconscious and you cannot express your own wishes about the health care you receive.**

5. Following the "Anatomical Gift section" is a space to check whether or not you have completed a **Health Care Power of Attorney**. Immediately below this space is a place for you to date and sign the form. **Remember, the Living Will is not considered valid or effective unless you do one of the following:**

> **First Option** – Date and sign the **Living Will** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.
>
> OR
>
> **Second Option** – Date and sign the **Living Will** in the presence of a notary public and have the **Living Will** notarized on the appropriate space provided on the form.

The following people may **not** serve as a witness to your **Living Will**:

- Anyone related to you by blood, marriage or adoption (this includes your husband or wife and your children);
- Your attending physician;
- If you are in a nursing home, the administrator of the nursing home.

6. Once you have filled out the **Living Will** and either signed it in the presence of witnesses or in the presence of a notary public, then it is a good idea to give a copy to your personal physician and any contacts you have listed in the **Living Will**. In some Ohio counties, people may be able to register their **Living Wills** with the county recorder. However, it is important to keep in mind that a registered **Living Will** form becomes a public record.

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 controls 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 documents, you should keep copies of both documents together, with your other important papers, and bring copies of both your Living Will and your Health Care Power of Attorney with you whenever you are a patient in a health care facility.

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association

OSBA Ohio State Bar Association

State of Ohio
Living Will Declaration
of

_____

(Print Full Name)

_____

(Birth Date)

I state that this is my Ohio Living Will Declaration. I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my wish that my dying not be artificially prolonged. If I am unable to give directions regarding the use of life-sustaining treatment when I am in a terminal condition or a permanently unconscious state, I intend that this Living Will Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

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

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

Cardiopulmonary resuscitation or **CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Declarant means the person signing this document.

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

Do Not Resuscitate or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means another document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or **Living Will** means this document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and my surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Terminal condition or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

Health Care if I Am in a Terminal Condition. If I am in a terminal condition and unable to make my own health care decisions, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR and artificially or technologically supplied nutrition or hydration; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

Health Care if I Am in a Permanently Unconscious State. If I am in a permanently unconscious state, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

Special Instructions. **By placing my initials at number 3 below, I want to specifically authorize my physician to withhold or to withdraw artificially or technologically supplied nutrition or hydration if:**

1. **I am in a permanently unconscious state; and**
2. **My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and**
3. **I have placed my initials on this line: _____**

Notifications. *[Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]*

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority:

[Note: If you do not name two contacts, you may wish to cross out the unused lines.]

First Contact:	Second Contact:
Name: _____	Name: _____
Address: _____	Address:_____
_____	_____
Telephone:_____	Telephone: _____

Anatomical Gift (optional)

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

____ I wish to make an anatomical gift.

____ I *do not* wish to make an anatomical gift.

Upon my death, the following are my directions regarding donation of all or part of my body:
In the hope that I, _____ (name of donor), may help others upon my death, I hereby give the following body parts: _____
(indicate specific parts or all body parts) for any purpose authorized by law: transplantation, therapy, research or education. *[Cross out any purpose that is unacceptable to you.]*

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

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

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

_____Yes_____No

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

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Health Care Power of Attorney. I have completed a Health Care Power of Attorney:

_____ Yes _____ No

SIGNATURE

[See below for witness or notary requirements.]

I understand the purpose and effect of this document and sign my name to this Living Will Declaration on _____, 20 _____, at _____, Ohio.

_____

DECLARANT

[You are responsible for telling members of your family, the agent named in your Health Care Power of Attorney (if you have one), and your physician about this document. You also may wish to tell your religious advisor and your lawyer that you have signed a Living Will Declaration. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Living Will Declaration with your county recorder for safekeeping.]

WITNESSES OR NOTARY ACKNOWLEDGMENT

[Choose one.]

[This Living Will Declaration will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, ***or*** *it is acknowledged before a Notary Public.]*

[The following persons ***cannot*** *serve as a witness to this Living Will Declaration: the agent or*

any successor agent named in your Health Care Power of Attorney; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]

Witnesses. I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in the Declarant's Health Care Power of Attorney, I am not the attending physician of the Declarant, I am not the administrator of a nursing home in which the Declarant is receiving care, and I am an adult not related to the Declarant by blood, marriage or adoption.

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

OR

Notary Acknowledgment.
State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Living Will Declaration as the Declarant, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)

_____

(name of donor)

INSTRUCTIONS: In addition to completing the references to Anatomical Gifts in your Living Will and Ohio Health Care Power of Attorney you should also complete and file the "Donor Registry Enrollment Form" with the Ohio Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organ and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Ohio Donor Registry and will be accessible only to the appropriate organ, tissue or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions.

To register for the Donor Registry, please complete this form, detach and send the original to:

Ohio Bureau of Motor Vehicles
ATTN: Record Clearance Unit
P.O. Box 16784
Columbus, Ohio 43216-6784

Make a copy of this form and retain it as part of your Living Will Declaration.

[This form must be signed by two witnesses. If the donor is under the age of 18, a parent or legal guardian must sign as one of the two witnesses.]

[This form should be used to state your intentions to be included in or removed from the Ohio Bureau of Motor Vehicles Donor Registry.]

Please indicate below:

____Please include me in the Donor Registry

____Please remove me from the Donor Registry

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association

OSBA Ohio State Bar Association

Print or type full name of living donor_____

Mailing Address _____

City _____State_____Zip _____

Phone ( ) _____Date of Birth _____

Driver's License or ID Card Number _____

Social Security Number _____

In the hope that I, _____ (name of donor), may help others upon my death, the following are my directions regarding donation of all or part of my body.

___ On my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

OR

___ On my death, I make an anatomical gift of the following specified organ, tissues, or eyes for any purposes indicated below:

☐ Any or all	☐ Liver	☐ Bone/ligament	☐ Heart valves
☐ Heart	☐ Kidneys	☐ Veins	☐ Skin
☐ Lung	☐ Pancreas	☐ Eyes	☐ Other

☐ Any purpose authorized by law or, specifically as indicated below:

- ☐ Transplantation
- ☐ Therapy
- ☐ Research
- ☐ Education
- ☐ Advancement of medical science
- ☐ Advancement of dental science

_____

Signature of Donor

_____

Date of Birth of Donor Date Signed

_____

Witness Date

_____

Witness Date