

**State of Ohio**

**Living Will Declaration**

For: \_\_\_\_\_



This form made available for your convenience as a public service by:

**JUDGE MARK J. BARTOLOTTA**

Lake County Probate Court  
25 N. Park Pl.  
Painesville, Ohio 44077



# 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 may give 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 cardiopulmonary resuscitation (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. 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.
- ◆ If a decision is made to withhold or withdraw life-sustaining treatment, 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. On page four of the Living Will form, there is a space 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.

1. Read over all information carefully. Important definitions are included in the document.
2. On the first two lines on page 2 of the form, print your full name and birth date.
3. On page 4, you may indicate whether you have completed a Health Care Power of Attorney. The next section of the form 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 decision is made to withhold or withdraw life-sustaining treatment.
4. On page 5 of the form is a box next to the **boldface** section which 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 in this box.



5. On page 6 of the form 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.

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

- *Primary agent in the declarant's Health Care Power of Attorney;*
- *The nominated guardian of the declarant's person or estate;*
- *Alternate or successor agent in the declarant's Health Care Power of Attorney;*
- *Anyone related to the declarant by blood, marriage or adoption (the declarant's spouse and children);*
- *The declarant's attending physician;*
- *The administrator of the nursing home where the declarant is receiving care.*

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.

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 takes precedence over a Health Care Power of Attorney.

*[You should consider completing a new Living Will Declaration if your medical condition changes or if you later decide to complete a Health Care Power of Attorney. If you have both a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.]*



# Ohio Living Will Declaration

[R.C. §2133]

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(Print Full Name)

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(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my direction that my dying not be artificially prolonged. [R.C. §2133.02 (A)(1)]

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

## Definitions

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

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

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

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

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

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

**Declarant** means the person signing the Living Will Declaration.

**Do Not Resuscitate or DNR Order** means a physician’s medical order that is written into a patient’s record to indicate that the patient should not receive cardiopulmonary resuscitation.

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

**Health care decision** means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

**Health Care Power of Attorney** means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

**Life-sustaining treatment** means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

**Living Will Declaration** means a legal document that lets a competent adult (“declarant”) specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person’s estate after death.

**Permanently unconscious state** means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

**Principal** means a competent adult who signs a Health Care Power of Attorney.

**Terminal condition** means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's attending physician and one other physician who has examined the declarant, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

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

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

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

I have completed a **Health Care Power of Attorney:** Yes \_\_\_\_\_ No \_\_\_\_\_

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

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority *[cross out any unused lines]*: [R.C. §2133.05(2)(a)]

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

If I am in a **TERMINAL CONDITION** and unable to make my own health care decisions, OR if I am in a **PERMANENTLY UNCONSCIOUS STATE** and there is no reasonable possibility that I will regain the capacity to make informed decisions, then I direct my physician to let me die naturally, providing me only with **comfort care**.



For the purpose of providing comfort care, I authorize my physician to:

1. Administer no life-sustaining treatment, including CPR;
2. Withhold or withdraw artificially or technologically supplied nutrition or hydration, provided that, if I am in a permanently unconscious state, I have authorized such withholding or withdrawal under **Special Instructions** below and the other conditions have been met;
3. Issue a DNR Order; and
4. Take no action to postpone my death, providing me with only the care necessary to make me comfortable and to relieve pain.

**Special Instructions.**

**By placing my initials, signature, check or other mark in this box, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw, consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain. [R.C. §2133.02(A)(3) and R.C. §2133.08]**

**Additional instructions or limitations.**

*[If the space below is not sufficient, you may attach additional pages.  
If you do not have any additional instructions or limitations, write "None" below.]*

*[The "anatomical gift" language provided below is required by ORC §2133.07(C). Donate Life Ohio recommends that you indicate your authorization to be an organ, tissue or cornea donor at the Ohio Bureau of Motor Vehicles when receiving a driver license or, if you wish to place restrictions on your donation, on a Donor Registry Enrollment Form (attached) sent to the Ohio Bureau of Motor Vehicles.]*

*[If you use this living will to declare your authorization, indicate the organs and/or tissues you wish to donate and cross out any purposes for which you do not authorize your donation to be used. Please see the attached Donor Registry Enrollment Form for help in this regard. In all cases, let your family know your declared wishes for donation.]*

**ANATOMICAL GIFT (optional)**

Upon my death, the following are my directions regarding donation of all or part of my body: In the hope that I may help others upon my death, I hereby give the following body parts: *[Check all that apply.]*

All organs, tissue and eyes for any purposes authorized by law.

OR

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

For the following purposes authorized by law:

- All purposes   Transplantation   Therapy   Research   Education

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.

**SIGNATURE of DECLARANT**

I understand that I am responsible for telling members of my family, the agent named in my Health Care Power of Attorney (if I have one), my physician, my lawyer, my religious advisor and others about this Living Will Declaration. I understand I may give copies of this Living Will Declaration to any person.

I understand that I must sign (or direct an individual to sign for me) this Living Will Declaration and state the date of the signing, and that the signing either must be witnessed by two adults who are eligible to witness the signing OR the signing must be acknowledged before a notary public. [R.C. §2133.02]

I sign my name to this Living Will Declaration

on \_\_\_\_\_, 20\_\_\_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
Declarant

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

**WITNESSES** [R.C. §2133.02(B)(1)]

*[The following persons CANNOT serve as a witness to this Living Will Declaration:*

- *Your agent in your Health Care Power of Attorney, if any;*
- *The guardian of your person or estate, if any;*

- Any alternate agent or guardian, if any;
- Anyone related to you by blood, marriage or adoption (for example, your spouse and children);
- Your attending physician; and
- The administrator of the nursing home where you are receiving care.]

***I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.***

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

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

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

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

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

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

State of Ohio

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

On \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned notary public, personally appeared \_\_\_\_\_, declarant of the above Living Will Declaration, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

\_\_\_\_\_  
 Notary Public

My Commission Expires: \_\_\_\_\_

My Commission is Permanent: \_\_\_\_\_

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