

Living Will Sample Ohio (aka "Advanced Medical Directive")

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ADVANCE MEDICAL DIRECTIVE AND POWER OF ATTORNEY FOR HEALTH CARE GIVEN BY JAMES ROBERT HEDGES

NOTICE TO ADULT EXECUTING THIS DOCUMENT

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

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself. You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

- a. You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.
- b. You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience

pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR ATTORNEY IN FACT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.);

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

(4) REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:

- A. YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.
- B. YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.
- C. IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:
 - I. INCLUDING A STATEMENT IN CAPITAL LETTERS OR OTHER CONSPICUOUS TYPE, INCLUDING, BUT NOT LIMITED TO, A DIFFERENT FONT, BIGGER TYPE, OR BOLDFACE TYPE, 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 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 the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate

your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

* * * * *

PART 1 POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me: **Sara Jane Hedges** whose residence is 1212 Holiday Drive, Louisville, KY.

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including those forms of health care necessary to keep me alive. Furthermore, the authority I give my agent shall include decisions to provide, withhold, or withdraw artificial nutrition. The power of my agent granted herein shall not be affected by my subsequent incapacity.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and documented in my medical records that I am either terminally ill **or** that I am in a state of persistent unconsciousness with no reasonable expectation of recovery.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance

with this power of attorney for health care and any instructions I give in Part 2 of this form. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

**PART 2
INSTRUCTIONS FOR HEALTH CARE**

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration, I express to my physician, family and friends my intent.

(6) **END-OF-LIFE DECISIONS:** In cases where both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and document in my medical records that I am either terminally ill or that I am in a state of persistent unconsciousness with no reasonable expectation of recovery, I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have stated below. The word "Withhold" shall be used to mean both withholding the treatment if it has not yet been given and withdrawing the treatment if it is currently being administered.

* Artificially supplied nutrition and hydration (including tube feeding or food and water)	Withhold
* Surgery or other invasive procedures (i.e., those where medical instruments must enter the body)	Withhold
* Heart-lung resuscitation (CPR)	Withhold
* Antibiotics	Do NOT Withhold
* Kidney or Renal dialysis	Withhold
* Mechanical ventilator (respirator)	Withhold
* Chemotherapy and other radiation therapy	Withhold
* All other "life sustaining" medical procedures that are merely intended to keep me alive without reasonable hope of improving my condition	Withhold

I hereby acknowledge the above choices and, also, hereby wish to specifically authorize my agent to refuse or withdraw informed consent to the provision of nutrition or hydration to me if I am in a permanently unconscious state and if it is determined that nutrition or hydration will no longer serve to provide comfort to me or alleviate my pain:

JAMES ROBERT HEDGES

Declarant / Principal

(7) **RELIEF FROM PAIN:** I direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

(8) **HIPAA Privacy Authorization.** I hereby authorize my Agent to execute any form authorization for use or disclosure of my Protected Health Information relating to past, present or future medical records required by the Health Insurance Portability and Accountability Act ("HIPAA"). My Agent is authorized to execute a HIPAA form authorization for release of my medical records in favor of any health provider or other party that the Agent deems appropriate.

**PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)**

(10) **ORGAN DONATION:** Upon my death, I wish to donate any and all of my organs, tissues, or other bodily parts for use in transplant to another human being. I authorize my health care agent to give consent to the medical organization of his choosing for donation of my aforementioned body parts.

**PART 4
PRIMARY PHYSICIAN
(OPTIONAL)**

(11) **DESIGNATION OF PHYSICIAN:** I designate the following physician as my primary physician: John Paul Jones, MD.

* * * * *

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

(13) **DURABILITY OF HEALTH CARE AGENT'S POWERS:** This Health Care Power of Attorney is a durable power of attorney and the authority of my agent shall not terminate if I become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive. If I have also

executed a durable financial power of attorney, this document is not meant to override that document. My health care agent's powers only extend to health care decisions as outlined in this document.

(14) DEFINITIONS:

"Artificially Provided Nutrition and Hydration" means feeding a patient through a means that is not natural such as (1) intravenously (i.e., inserting a needle directly into a patient's veins through which food or water would be forced into the patient's blood stream) or (2) a feeding tube inserted in the nose or mouth through which food or water would be forced into an individual's stomach. Assisted feeding, such as by a spoon or bottle, where the patient actively participates in the feeding process by chewing or swallowing is not considered "artificially provided nutrition and hydration".

"Persistently Unconscious" and "Permanently Unconscious" mean a condition that, to a reasonable degree of medical certainty: (a) will last permanently without improvement, (b) one in which cognitive thought, purposeful action, and awareness of self and environment are absent, and (c) which has existed for a period of time sufficient, in accordance with applicable medical standards, to make a diagnosis called for in parts (a) and (b) hereof.

"Terminally Ill" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, to a reasonable degree of medical certainty, result in death within a relatively short time.

"Life-Sustaining Treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to the patient, would serve only to prolong the dying process where the patient has a terminal illness or injury, or would serve only to maintain the patient in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, surgery, chemotherapy, CPR, dialysis, use of mechanical respirators, blood transfusions, and the administration of all drugs and antibiotics (except those intended to ease pain).

IN WITNESS WHEREOF, I sign the foregoing as my Health Care Directive and Medical Power of Attorney, do it willingly and as my free and voluntary act for the purposes herein expressed, and further state that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence, this ____ day of March, 2007.

_____ (Please also sign on page 5 above.)

JAMES ROBERT HEDGES

Declarant / Principal

City and State of Residence: Springfield, Error: Error: expected [/HIDEIF], but found [/showif] instead[/showif]Ohio

Social Security Number: _____

STATE OF OHIO)

) SS.

COUNTY OF _____)

I, the undersigned, a Notary Public authorized to administer oaths in the State of Ohio, certify that JAMES ROBERT HEDGES, the Declarant of this instrument, having personally appeared before me and having been first duly sworn, has declared to me that he or she has willingly signed and executed the instrument as his or her Medical Directive and Medical Power of Attorney, and that he or she executed such instrument as his or her free and voluntary act for the purposes therein expressed.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal this ____ day of March, 2007.

_____ My Commission Expires: _____

Notary Public

(Note: This page is **not** to be attached to your Health Care Directive.)

INSTRUCTIONS REGARDING EXECUTION OF YOUR HEALTH CARE DIRECTIVE AND MEDICAL POWER OF ATTORNEY

- A. Please remember to fill in your social security number below your name on the signature page.
- B. **Please note that the principal's signature is required on pages 4 and 6 of this document.**
- C. We recommend that you execute two originals of your Health Care Directive. Give the first original to the Health Care Agent you named and you retain the second original in your home in place known to family members. If you currently under medical care for a serious medical condition, we also suggest you execute a third original and give it to your primary physician.
- D. **Witnesses.** We have written this health care directive to be valid in all 49 states (and the District of Columbia) whose laws allow for this type of document. There are varying rules among the states regarding what types of persons cannot witness a health care directive. As such, we have included with our form all the prohibitions against witness from the across the country making the list somewhat length. The following persons cannot act as a witness to a health care directive:
1. A health care provider for Declarant,
 2. An employee of a health care provider for Declarant,
 3. The operator or employee of a community or long-term care facility,
 4. Patient in a health care facility in which declarant is a patient,
 5. Individual with a claim against Declarant's estate,
 6. Individual who has a financial responsibility for Declarant's medical care, and
 7. Individual related by blood, marriage, or adoption to Declarant.
- Also, the health care agent should not be one of the witnesses to this document.** The two witnesses need to be physically present when you sign the health care directive and attest to the fact that they saw you sign the document. If you have the document notarized, the witnesses will need to be with you in front of the notary.
- E. Where do I get a notary? Your local bank is the best place to find a notary. If you cannot find a notary at your bank, please consult your local Yellow Pages which has them listed under "notaries public".
- F. Notice: This form is not intended for use in the State of Wisconsin.
- G. What if I decide to make changes to my document? We will keep your responses to the online questionnaire in our database **for 60 days after the date of purchase**. During this time, you may go to the User Administration section of our site to call up your form questionnaire and make changes—the URL is <https://www.medlawplus.com/user/>. You shall need your "user name" and "password" to re-enter the system. Once in the User Administration area, click on the text link to your form questionnaire which is located on the upper-left of the page. Make the desired changes to your responses in the questionnaire and submit to create a revised document. If you have problems calling up your old data, email us at administrator@medlawplus.com. We do our best to give a prompt response to all inquiries, usually within a few hours. NOTE: Upon registration, our system emailed to you our record of your "user name" and "password".

DISCLAIMER

The above is provided for informational purposes only and is NOT to be relied upon as legal advice. This service is not a substitute for the advice of an attorney and we encourage users to have all documents created on our site reviewed by an attorney. No attorney-client relationship is established by use of our online legal forms system and the user is not to rely upon any information found anywhere on our site. **THESE FORMS ARE SOLD ON AN "AS IS" BASIS WITH NO WARRANTIES OR GUARANTIES.** If you wish personal assistance in deciding whether the document found on our site is right for you or desire representations and warranties upon the legality of the document you are purchasing in the jurisdiction you will be using it, contact an attorney licensed to practice law in your state.