The Ohio State Bar Association

STATE OF OHIO
LIVING WILL DECLARATION

I, _____ , presently residing at _____ , Ohio, (the "Declarant"), being of sound mind and not under or subject to duress, fraud or undue influence, intending to create a Living Will Declaration under Chapter 2133 of the Ohio Revised Code, as amended from time to time, do voluntarily make known my desire that my dying shall 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, it is my intention that this Living Will Declaration shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment. I am a competent adult who understands and accepts the consequences of such refusal and the purpose and effect of this document.

In the event I am in a terminal condition, I do hereby declare and direct that my attending physician shall:

1. administer no life-sustaining treatment;
2. withdraw such treatment if such treatment has commenced; and
3. permit me to die naturally and provide me with only that care necessary to make me comfortable and to relieve my pain but not to postpone my death.

In the event I am in a permanently unconscious state, I do hereby declare and direct that my attending physician shall:

1. administer no life-sustaining treatment, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal;
2. withdraw such treatment if such treatment has commenced; and,
3. permit me to die naturally and provide me with only that care necessary to make me comfortable and to relieve my pain but not to postpone my death.

☐ _____IN ADDITION, IF I HAVE MARKED THE FOREGOING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, I AUTHORIZE MY ATTENDING PHYSICIAN TO WITHHOLD, OR IN THE EVENT THAT TREATMENT HAS ALREADY COMMENCED, TO WITHDRAW, THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY SUPPLIED NUTRITION AND HYDRATION, IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT SUCH NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, he or she shall make a good faith effort and use reasonable diligence to notify one of the persons named below in the following order of priority:

1. _____ , _____
(Name) (Relationship)

presently residing at_____ Phone:_____

2. _____ , _____
(Name) (Relationship)

presently residing at_____ Phone:_____

For purposes of this Living Will Declaration:

(A) "Life-sustaining treatment" means any medical procedure, treatment, intervention, or other measure including artificially or technologically supplied nutrition and hydration that, when administered, will serve principally to prolong the process of dying.

(B) "TERMINAL CONDITION" MEANS AN IRREVERSIBLE, INCURABLE, AND UNTREATABLE CONDITION CAUSED BY DISEASE, ILLNESS, OR INJURY TO WHICH, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AS DETERMINED IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS BY MY ATTENDING PHYSICIAN AND ONE OTHER PHYSICIAN WHO HAS EXAMINED ME, BOTH OF THE FOLLOWING APPLY:

(1) THERE CAN BE NO RECOVERY, AND

(2) DEATH IS LIKELY TO OCCUR WITHIN A RELATIVELY SHORT TIME IF LIFE-SUSTAINING TREATMENT IS NOT ADMINISTERED.

(C) "PERMANENTLY UNCONSCIOUS STATE" MEANS A STATE OF PERMANENT UNCONSCIOUSNESS THAT, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AS DETERMINED IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS BY MY ATTENDING PHYSICIAN AND ONE OTHER PHYSICIAN WHO HAS EXAMINED ME, IS CHARACTERIZED BY BOTH OF THE FOLLOWING:

(1) I AM IRREVERSIBLY UNAWARE OF MYSELF AND MY ENVIRONMENT, AND

(2) THERE IS A TOTAL LOSS OF CEREBRAL CORTICAL FUNCTIONING, RESULTING IN MY HAVING NO CAPACITY TO EXPERIENCE PAIN OR SUFFERING.

I understand the purpose and effect of this document and sign my name to this Living Will Declaration after careful deliberation on _____ at _____ , Ohio.
(Date) (City)

_____
DECLARANT

THIS LIVING WILL DECLARATION WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY TWO ELIGIBLE WITNESSES AS DEFINED BELOW WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

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 the attending physician of the Declarant, I am not the administrator of a nursing home in which the Declarant is receiving care, and that I am an adult not related to the Declarant by blood, marriage or adoption.

Signature: _____ Residence Address: _____

Print Name:_____ _____

Date: _____ _____

Signature: _____ Residence Address: _____

Print Name:_____ _____

Date: _____ _____

OR

ACKNOWLEDGMENT

State of Ohio
County of _____ss:

On this the _____day of _____, 19____ , 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 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.

My Commission
Expires:_____

_____
Notary Public

NOTE: YOU MAY WISH TO GIVE EXECUTED COPIES OF THIS LIVING WILL DECLARATION TO YOUR AGENT UNDER ANY DURABLE POWER OF ATTORNEY FOR HEALTH CARE YOU HAVE EXECUTED, TO YOUR LAWYER, YOUR PERSONAL PHYSICIAN AND MEMBERS OF YOUR FAMILY.

NOTICE TO DECLARANT

This form of a Living Will Declaration is designed to serve as evidence of an individual's desire that life-sustaining medical treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if the individual is unable to make informed treatment decisions and is in a terminal condition or is in a permanently unconscious state.

If you would not choose to withhold or to withdraw any or all forms of life-sustaining treatment, you have the legal right to so choose and you might want to state your medical treatment preferences in writing in another form of Declaration.

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 consider preparing a Durable Power of Attorney for Health Care.

As a public service, a special committee of the Ohio State Bar Association prepared this form, which has been approved by the Ohio State Medical Association.

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