OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, am an adult of sound mind who currently resides in _____County, Ohio. After careful consideration, I knowingly and voluntarily make this durable power of attorney for health care and declaration of treatment preferences. I understand that this is a legally binding document.

I understand that this document will take effect only if my attending physician determines that my ability to receive and evaluate information is impaired to such an extent that I have lost the capacity to make informed health care decisions for myself. My agent can then begin making all physical and mental health care decisions for me. My agent will continue making all health care decisions for me until my attending physician determines that I have regained the capacity to make those decisions for myself.

I appoint the following person(s) to act as my agent to make health care decisions for me if my attending physician determines that I have lost the capacity to make informed health care decisions for myself. My agent has authority to make all physical and mental health care decisions for me, including the right to give, to refuse to give, or to withdraw informed consent to any health care treatment, as allowed by law.

I instruct my agent to make health care decisions for me consistent with my wishes as expressed in this document or, if not expressed here, as otherwise made known to my agent by me. If my agent does not know and is not able to determine what I want, I instruct my agent to act in what my agent believes to be my best interest.

I intend each of the individuals named below to succeed to the authority of and serve under this appointment, in the order named, if at any time the prior agent is not readily available or is unwilling to serve or to continue to serve, or is removed by me.

I appoint_____,whose address is _____,whose daytime phone is: _____, and evening phone is _____ as my agent to make all health care decisions for me. In the event this person is unavailable:

I appoint_____,whose address is _____,whose daytime phone is: _____, and evening phone is _____ as my agent to make all health care decisions for me. In the event this person is unavailable:

I appoint_____,whose address is _____,whose daytime phone is: _____, and evening phone is _____ as my agent to make all health care decisions for me.

I understand that I can revoke this document at any time and in any manner merely by expressing my intention to revoke it. This can be done verbally or in writing. If I have given a copy of this document to a physician, my revocation will not be effective as to that physician until the fact of my revocation is communicated to that physician (or the physician's staff) by me or by a witness to the revocation. I understand that if I execute a

new durable power of attorney for health care, the new document will automatically replace this one.

This durable power of attorney for health care has no expiration date, and shall not be affected by my disability or by the passage of time.

If a court finds any provision of this document to be invalid or unenforceable, that provision shall be severed from this document without affecting any other power or provision of this document, or the appointment of my agent to make health care decisions for me.

[ ]_____IF I HAVE MARKED THE FOREGOING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT MAY REFUSE, OR IN THE EVENT TREATMENT HAS ALREADY COMMENCED, WITHDRAW INFORMED CONSENT TO 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.

If I have signed an earlier durable power of attorney for health care, it will be automatically revoked by this document. If I have signed a declaration under Revised Code Chapter 2133 (commonly called a "Living Will"), it will not be revoked by this document.

I understand that I should give copies of this document to the agent and alternate agents I have named in this document. I may also give a copy to my physician, psychiatrist, or other health care provider. However, I understand that if I give a copy of this document to my physician or psychiatrist and later revoke this document, my revocation does not become effective as to the physician or psychiatrist until I or a witness to the revocation notifies him/her (or his/her staff) that I have revoked this document. I understand that both my revocation and notice of revocation to my physician or psychiatrist can be done either verbally or in writing. However, it may be easier to prove I revoked it if I do so in writing.

I can make changes to this document before I sign it, and I agree to write my initials beside those changes. I understand that I cannot make changes to this document after I have signed it. Instead I must execute a new document.

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

I understand that this document will not be valid unless I sign it in the presence of either a notary public or two witnesses who meet the law's requirements.

THIS DURABLE POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I understand the terms and purpose of this document, and I sign my name after carefully considering this matter on this _____day of _____ 200__, at _____County, Ohio.

_____
Signature of Principal

_____
Typed or printed name of Principal

WITNESSES

I attest that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and not subject to duress, fraud, or undue influence. I also attest that I am not an agent named in this document, I am not the attending physician of the principal, I am not the administrator of a nursing home in which the principal is receiving care, and that I am an adult who is not related to the principal by blood, marriage or adoption.

Signature:_____ Residence Address:_____

Print name: _____ _____

Date: _____ _____

Signature:_____ Residence Address:_____

Print name: _____ _____

Date: _____ _____

NOTARY ACKNOWLEDGMENT

State of Ohio
County of _____ss:

On this the ____day of _____, 20 ___, _____ who is known to me or who has provided me with satisfactory proof of identity as the person whose name is subscribed above as the principal, personally appeared before me and acknowledged that s/he executed this document for the purposes described in the document. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.
My Commission Expires _____

_____
Notary Public

The law requires the following notice to be included in this document:

NOTICE TO ADULT EXECUTING THIS DOCUMENT (R.C. SEC.1337.17)

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 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 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 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 the attorney in fact's 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 your 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.