

**STATE OF OHIO**  
**HEALTH CARE POWER OF ATTORNEY**  
**OF**

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**DOB:** \_\_\_\_\_

I state that this is my Health Care Power of Attorney and I revoke any prior Health Care Power of Attorney 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.

This Health Care Power of Attorney is in effect only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision and that inability is verified by my attending physician. However, this does not require or imply that a court must declare me incompetent.

**PREAMBLE.** My Roman Catholic and Christian heritage holds that life is the gift of a loving God.

I understand and believe, as a Catholic, that I may never choose to directly cause or hasten my death. I believe that euthanasia is the deliberate act or taking the life of another, whether by active intervention or by omitting an action with the intention of causing death. I believe that euthanasia constitutes an unwarranted destruction of human life and is never morally permissible.

I also believe that suicide (and assisted suicide) are never morally permissible.

I understand that I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to understand, make or communicate my own health care decisions. In such circumstances, those caring for me will need direction concerning my care and will turn to someone who knows my values and health care wishes. I am, therefore, signing this Health Care Power of Attorney [which is my advance directive for health care] to provide the guidance and authority needed to implement decisions for me, and especially if I have an end-stage medical condition or am permanently unconscious (as those terms are defined in Ohio law).

**RELIGIOUS INSTRUCTIONS AND LIMITATIONS.** I am a Roman Catholic from the Diocese of Cleveland, Ohio and believe that life is a precious gift from God. I believe that God intended for my life to be lived for His glory and my salvation. I know too that my earthly goal is to be united with God for eternal life. Therefore, I do not need to resist death if medical treatment is futile or disproportionately burdensome. My duly appointed health care agent may refuse medical treatments, as long as doing so is consistent with the authoritative teaching of the Roman Catholic Church such as that set forth in documents such as *The Gospel of Life* (Pope John Paul II, March 25, 1995); *Declaration on Euthanasia* (Congregation for the Doctrine of the Faith, 1980); *Patients in a "Permanent" Vegetative State* (Pope John Paul II, March 20, 2004); *Nutrition and Hydration: Moral Considerations* (The Catholic Bishops of Pennsylvania, Revised Edition, 1999); *Ethical and Religious Directives for Catholic Health Care Services* (U.S. Conference of Catholic Bishops, 2001); and *Responses to Certain Questions Concerning Artificial Nutrition and Hydration* (Congregation for the Doctrine of the Faith, 2007).

Medical treatments may be foregone, or withdrawn, if they do not offer me reasonable hope of benefit or are disproportionately burdensome, meaning the treatments will impose serious risks, excessive pain, excessive expense on the family or the community, or other extreme burden. My health care agent (or health care representative as designated by the law) is to presume in favor of providing me with nutrition and hydration, including medically assisted nutrition and hydration if they are capable of sustaining my life.<sup>1</sup>

I recognize that the civil law give my health care agent certain powers. These powers are to be exercised according to my wishes and religious beliefs as expressed above.

**DEFINITIONS UNDER OHIO LAW.** Several legal and medical terms are used in this document. For convenience they are explained below.

**Agent or attorney-in-fact** means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

**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.

**Comfort care** means any measure taken to diminish pain or discomfort, but not to postpone death.

**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.

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<sup>1</sup> Effective immediately and continuously until my death, or revocation by a writing signed by me or someone authorized by law to revoke this document, I authorize all health care providers or other covered entities to disclose to my health care agent, upon the agent’s request, any information, oral or written, regarding my physical or mental health. The information includes, but is not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information (such as that described or defined in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91, 100 Stat. 1936) and the regulations promulgated thereunder and any other State or local laws and rules).

**Health Care Power of Attorney** means this 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 another 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 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.

**Principal** means the person signing this document.

**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.

**NAMING OF MY AGENT.** The person named below is my agent who will make health care decisions for me as authorized in this document:

my \_\_\_\_\_, \_\_\_\_\_, presently residing at \_\_\_\_\_,  
\_\_\_\_\_  
telephone number \_\_\_\_\_.

**NAMING OF ALTERNATE AGENT.** Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name the following person as my alternate agent:

my \_\_\_\_\_, \_\_\_\_\_, presently residing at \_\_\_\_\_,  
\_\_\_\_\_  
telephone number \_\_\_\_\_.

Any person can rely on a statement by alternate agent named above that he/she is properly acting under this document and such person does not have to make any further investigation or inquiry.

**GUIDANCE TO AGENT.** My agent will make health care decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make health care decisions in my best interests. My agent will determine my best interests after considering the benefits, the burdens, and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

**AUTHORITY TO AGENT UNDER OHIO LAW.** My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following:

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.
2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.
3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.
4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.
5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.
6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.
7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.
8. To select, employ, and discharge health care personnel and services providing home health care and the like.
9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.
10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:
  - (a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and
  - (b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and
  - (c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

**SPECIAL INSTRUCTIONS. By placing my initials at number 3 below, and subject to the Religious Instructions and Limitations set forth above, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of 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: \_\_\_\_\_**

**LIMITATIONS OF AGENT'S AUTHORITY.** I understand that under Ohio law, there are four limitations to the authority of my agent:

1. My agent cannot order the withdrawal of life-sustaining treatment unless I am in a terminal condition or a permanently unconscious state, and two physicians have confirmed the diagnosis and have determined that I have no reasonable possibility of regaining the ability to make decisions; and
2. My agent cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and
3. My agent cannot order the withdrawal of artificially or technologically supplied nutrition or hydration unless I am terminally ill or permanently unconscious and two physicians agree that nutrition or hydration will no longer provide comfort or relieve pain and, in the event that I am permanently unconscious, I have given a specific direction to withdraw nutrition or hydration elsewhere in this document; and

4. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

**NO EXPIRATION DATE.** This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

**GUARDIAN.** I intend that the authority given to my agent will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate my agent to serve as the guardian of my person, without bond.

**ENFORCEMENT BY AGENT.** My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

**RELEASE OF AGENT'S PERSONAL LIABILITY.** My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

**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.

**LIVING WILL.** I have completed a Living Will.

**DONOR REGISTRY ENROLLMENT FORM.** I have completed the Donor Registry Enrollment Form: \_\_\_\_\_ Yes \_\_\_\_\_ No

[THE REMAINDER OF THIS PAGE LEFT INTENTIONALLY BLANK]

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, at \_\_\_\_\_.

\_\_\_\_\_

**ACKNOWLEDGMENT**

STATE OF OHIO                    )  
  ) ss:  
COUNTY OF CUYAHOGA        )

On this \_\_\_\_\_ day of \_\_\_\_\_, 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 Health Care Power of Attorney as the Principal, and acknowledged that he/she executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

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

This instrument prepared by:  
PAUL J. STANO CO. LPA  
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