

**STATE OF OHIO
LIVING WILL DECLARATION
OF**

DOB: _____

I state that this is my Ohio Living Will Declaration. 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 wish that my dying not be artificially prolonged.

This Living Will shall take effect when my attending physician determines that I am incompetent which means that I lack sufficient capacity to understand the potential material benefits, risks and alternatives involved in a specific proposed health care decision; I am unable to make the health care decision on my behalf; or I am unable to communicate a decision about my health care.

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, I intend that this Living Will Declaration be honored by my family and physicians as the final expression of my legal right to refuse health care.

RELIGIOUS INSTRUCTIONS AND LIMITATIONS. I direct that those responsible for my care to make health care decisions according to the principles and authoritative teachings of my Roman Catholic faith and what they know about my stated wishes. I hereby declare and make known my instructions and wishes for my future health care, and direct that the following health care decisions be implemented. I affirm that the statements and principles listed in the Preamble and Religious Instructions and Limitations of my Health Care Power of Attorney shall apply also to this Living Will Declaration.

I ask that if I fall terminally ill, I be told so I might prepare myself for death. If I am unable to understand, communicate or make decisions for myself, I direct that a Catholic priest be contacted to attend to my spiritual needs so I may receive the Sacraments of Reconciliation and the Anointing of the Sick, Viaticum, and be supported by prayer.

If my doctor determines that I have an end-stage medical condition and my death is imminent, I direct that treatment that will only maintain a precarious and burdensome prolonging of my life be foregone or withdrawn. However, treatment should not be withdrawn if my health care agent judges there are special and significant reasons why it should continue.

I believe that I do not have to use ethically extraordinary or disproportionate medical treatments for sustaining life if they are excessively burdensome or do not offer any reasonable hope of benefit. I understand that this belief is consistent with authoritative Catholic teaching.

I direct that, regardless of my physical or mental condition, all ordinary medical care necessary to relieve pain and make me comfortable (including medically assisted nutrition and hydration) be provided if it offers a reasonable hope of benefit and is not excessively burdensome.

If I am unable (even with assistance) to take food and drink orally, I desire that medically assisted nutrition and hydration be provided to me so long as it is capable of sustaining my life. Even if I am permanently unconscious, medically assisted nutrition and hydration should be continued. It should be discontinued if it is futile (no longer able to sustain my life). It should be discontinued if it imposes disproportionate burdens to me (serious risk, excessive pain, excessive expense on the family or the community, or some other extreme burden) or if death is both inevitable and so imminent that continuing medically assisted nutrition and hydration is judged futile.

I direct that I receive appropriate medication to alleviate my pain, even though the administration of such medications may indirectly hasten my death. Pain medication should never be administered with the purpose of hastening my death.

I also direct that I not receive ethically extraordinary treatments, unless my health care agent judges that there are special and significant reasons why I should receive them. Rather than listing for my agent all specific forms of medical treatment, which I would or would not want, I direct that the directions and principles I have adopted by using this Living Will Declaration guide him or her.

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

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.

Declarant means the person signing this document.

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.

Health Care Power of Attorney means another 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 this 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 my 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.

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.

HEALTH CARE IF I AM IN A TERMINAL CONDITION. If I am in a terminal condition and unable to make my own health care decisions, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR and artificially or technologically supplied nutrition or hydration; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

HEALTH CARE IF I AM IN A PERMANENTLY UNCONSCIOUS STATE. If I am in a permanently unconscious state, I direct that my physician shall:

1. Administer no life-sustaining treatment, including CPR, except for the provision of artificially or technologically supplied nutrition or hydration unless, in the following paragraph, I have authorized its withholding or withdrawal; and
2. Withdraw such treatment, including CPR, if such treatment has started; and
3. Issue a DNR Order; and
4. Permit me to die naturally and take no action to postpone my death, providing me with only that care necessary to make me comfortable and to relieve my pain.

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 physician to withhold or to withdraw 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: _____

NOTIFICATIONS. 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:

1. my _____, _____, presently residing at _____, telephone number _____.
2. my _____, _____, presently residing at _____, telephone number _____.

NO EXPIRATION DATE. This Living Will Declaration will have no expiration date; however, I may revoke it at any time.

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.

HEALTH CARE POWER OF ATTORNEY. I have completed a Health Care Power of Attorney.

I understand the purpose and effect of this document and sign my name to this Living Will Declaration on this _____ day of _____, 20____, at _____, Ohio.

ACKNOWLEDGEMENT

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 Living Will Declaration as the Principal, and who has 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:
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