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DO YOU HAVE A LIVING WILL AND HEALTH CARE POWER OF ATTORNEY?

It is vital that every adult have a Living Will, a Health Care Power of Attorney, and if desired, a signed organ donor consent form. Together these are known as "Advance Directives." Advance Directives are the best way to ensure decisions about your health and well-being are made by someone *you* choose and in a manner consistent with *your* wishes.

If you desire to have our office prepare your Advance Directives please complete the attached worksheet and submit it to our office. An Information Guide is also attached for your reference.

As part of our service we will:

- Prepare a living will, health care power of attorney and the optional organ donor consent form;
- Meet with you before you sign the Advance Directives and answer questions you may have;
- Provide you a "wallet card" that you carry with you so that in the case of an emergency hospital personnel will know you have prepared Advance Directives and that they can obtain a signed copy from our office.
- Send copies of your Advance Directives to your doctor and to your health care agent;
- If applicable, prepare the organ donor consent form and submit it to the State of Ohio Donor Registry;

ADVANCE DIRECTIVES WORKSHEET

Name: _____ Phone: _____

Address: _____

Email: _____ Date of Birth _____ SOC SEC No: _____

Do you want us to send your Advanced Directives to your Doctor? (We recommend) ___Yes ___No

Primary Physician (name & address) _____

HEALTH CARE AGENTS: Please specify the "agent" you want to make health care decisions for you if you are unable to do so for yourself. You should also choose at least one alternate. (Most people choose a spouse or a child, however, you are free to choose just about anyone other then your doctor or an administrator of a health care facility where you might be treated.)

Name: _____ Phone: _____

Address: _____ Email: _____

First Alternate Agent (not required but recommended):

Name: _____

Address:_____

_____

Telephone:_____

Email: _____

Second Alternate Agent (not required):

Name: _____

Address: _____

_____

Telephone: _____

Email: _____

ORGAN AND TISSUE DONATION (OPTIONAL) (If you have already elected to be an organ donor through the BMV then please leave this blank):

Do you want to be an organ donor? Yes ____ No ____

If you answered "yes" please complete the following:

____ All organs, tissues and eyes, or the following:

ORGANS

___ Heart
___ Intestines
___ Lung
___Small Bowel
___ Liver (and associated vessels)
___ Kidneys (and associated vessels)
___ Pancreas/islet cells

TISSUES

___Eyes/Corneas
___ Heart valves
___Bone
___Tendons
___Ligaments
___Veins
___Fascia
___Skin
___Nerves

For the following purposes authorized by law:

___ All purposes ___Transplantation ___Therapy ___Research ___ Education

Driver's License or ID Card No.: _____

HEALTH CARE POWER OF ATTORNEY

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 above 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.

Notice as required by Ohio Revised Code §1337.17

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 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 communicates 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 when you 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.

Notice as required by Ohio Revised Code §1337.17

ADDENDUM
This notice was not updated when certain provisions of the law regarding the Health Care Power of Attorney were changed in March 2014. Please be advised of the following changes:

You may, but are not required to, authorize your agent to get your health information, including information that is protected by law and otherwise not available to your agent. You can authorize your agent to have access to your health information immediately upon your signing of this document or at any later time, even though you are still able to make your own health care decisions.

You may also, but are not required to, use this document to name guardians for you or your estate should guardianship proceedings be started.

LIVING WILL

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

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 prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration takes precedence over a Health Care Power of Attorney.

ORGAN AND TISSUE DONATION IN OHIO

One individual can save or improve the quality of life for people who suffer from organ failure, congenital defects, bone cancer, orthopedic injuries, burns, blindness and more. One organ donor can save up to 8 lives by donating heart, lungs, kidneys, pancreas, small intestine and liver. More than 123,000 Americans are on the national waiting list for a life-saving organ transplant; 3,400 in Ohio. Statistically, 18 people in the U.S. die every day while waiting for transplants. If you register as a donor, be sure to share the decision with your family members.

Who can become a donor? All individuals over the age of 15½ can register and give advance authorization for donation. Medical suitability for donation is determined at the time of death. If a minor dies before the age of 18, a parent can amend or revoke the donation decision.

Are there age limits for donors? People of all ages and medical histories should consider themselves potential donors. Newborns as well as senior citizens have been organ donors. Medical condition at the time of death will determine what organs and tissues can be donated.

If I join the Donor Registry, will it affect the quality of medical care I receive at the hospital? No, doctors at hospitals are concerned with caring for the patient in front of them and are not involved with donation and transplantation. Every effort is made to save your life before donation is considered.

Will donation disfigure my body? Can there be an open casket funeral? Donation does not disfigure the body and does not interfere with or delay a funeral, including open casket services.

Are there any costs to my family for donation? The donor's family does NOT pay for the cost of the donation. All costs related to donation of organs, eyes and tissues are paid by the designated recovery agency.

Does my religion approve of donation? All major religions support organ, eye and tissue donation as an unselfish act of charity.

Can I sell my organs? No. The National Organ Transplant Act makes it illegal to sell human organs and tissue. Violators are subject to fines and imprisonment. Among the reasons for this rule is the concern of Congress that buying and selling of organs might lead to inequitable access to donor organs, with the wealthy having an unfair advantage.

How are organs distributed? Donor organs are matched to recipients through a federally-regulated system based on a number of factors including blood type, body size, medical urgency, time on waiting list and geographical location.

Can I be an organ and tissue donor and also donate my body to science? Total body donation takes precedence over organ and tissue donation. If you wish to donate your entire body, you must make arrangements with a medical school or research facility prior to your death. Medical schools, research facilities and other agencies study bodies to gain greater understanding of anatomy and disease mechanisms in humans. This research is also vital to saving and improving lives.

Does the registry authorize living donation? No, living donation is not authorized by the registry. It is possible to donate a kidney, or part of a liver or lung while alive, but that is arranged on an individual basis through specific transplant centers.