Hospice of Dayton
324 Wilmington Ave.
Dayton, OH 45420
937 256 4490
www.hospiceofdayton.org

State of Ohio Living Will

Declaration of ____,
(Name)

Date of Birth _________________________.

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. 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.

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 Do Not Resuscitate 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 detailing Special Instructions, 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, I 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: ___________________

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 those designated by law (my guardian, spouse, adult children, parents or majority of adult siblings) or one of the following persons in the following order of priority (You are not required to name anyone. Please cross out any unused lines):

First Contact:

Name ___________________________

Address: _________________________

____

Telephone: _______________________

Second Contact:

Name:______________________________

Address: ___________________________

____

Telephone: ________________________

This Living Will Declaration has no expiration date. However I may revoke it at any time. Copies of the document are the same as the original. Any person may rely on a copy of this document. I intend that this document be honored in any jurisdiction to the extent allowed by law.

I have completed a Health Care Power of Attorney: _____Yes _____No

I understand the purpose and effect of this document and sign my name to this Living

Will Declaration on ____, _____________,
(date) (year)
At ____, Ohio.
(city)

Signature of Declarant: ____

(You may either have this document witnessed by two people or by a Notary Public of the State of Ohio. YOU DO NOT NEED BOTH. Either one is sufficient to validate the document.)

Witnesses: 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 an agent designated in the Declarant's Health Care Power of Attorney, I am not the attending physician or the Declarant, I am not the administrator of a nursing home in which the Declarant is receiving care, and I am an adult not related to the Declarant by blood, marriage or adoption.

Signature: ____ Date: ____________

Address: ____

Signature: ____ Date:____________

Address: ____

OR

Notary Acknowledgment.
State of Ohio
County of ___________________, ss

On ____________________________, _____________, before me, the undersigned
(date) (year)
Notary Public, personally appeared ____
(Declarant)

known to me or satisfactorily proven to be the person whose name is subscribed to the above Living Will Declaration as the Declarant, and who has 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.

____
Notary Public

My Commission Expires: ___________________________