



Please review Notice attachment, page 5, of this document before completion.

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

State of Ohio
Health Care Power of Attorney
Of

Print Full Name

Birth Date

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 cannot make healthcare decisions for myself. However, this does not require or imply that a court must declare me incompetent.

The person named below is my agent, who will make health care decisions for me as authorized in this document.

Agent's Name:

Agent's Current Address:

Agent's Current Telephone Number:

Should the agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

First Alternate Agent:

Second Alternate Agent:

Name:

Name:

Address:

Address:

Telephone:

Telephone:

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

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.

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. I have indicated by crossing out the specifics any authority that I do not want my agent to have.

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, 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 place my initials on this line: \_\_\_\_\_

I understand that under Ohio law, there are five 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. If I am pregnant, my agent cannot refuse or withdraw informed consent to health care if the refusal or withdrawal would end my pregnancy, unless the pregnancy or health care would create a substantial risk to my life or two physicians determine that the fetus would not be born alive; and
- 4. 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
- 5. 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.

Additional Instructions or Limitations: I authorize my agent to act upon the following additional instructions or limitations:

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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.

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.

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

My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

Any person may rely on a copy of this document.

I intend that this document will be honored in any jurisdiction to the extent allowed by law.

I have completed a Living Will:  Yes  No

I have made my wishes known regarding organ and tissue donation in my Living Will:  
 Yes  No

I have completed the Donor Registry Enrollment Form:  Yes  No

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

Care Power of Attorney on \_\_\_\_\_, \_\_\_\_\_ at  
(date) (year)  
\_\_\_\_\_, Ohio.  
(city)

Signature of Principal: \_\_\_\_\_

WITNESSES OR NOTARY ACKNOWLEDGEMENT (select one)

I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence; that the Principal 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 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 I am an adult not related to the Principal by blood, marriage or adoption.

First Witness:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

Second Witness:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

OR

Notary Acknowledgment,

State of Ohio

County of \_\_\_\_\_, ss

On \_\_\_\_\_, \_\_\_\_\_, before me, the  
(date) (year)  
undersigned Notary Public, personally appeared \_\_\_\_\_,  
(principal)

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 who has acknowledged that (s)he 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

My Commission Expires: \_\_\_\_\_

## NOTICE TO ADULT EXECUTING THIS DOCUMENT

*(This notice is included in this printed form as required by Ohio Revised Code 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 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 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 healthcare 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 then 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 documents. 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, 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 make 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 acknowledge your signature. No person who is related to you by blood, marriage, or adoption may serve as a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care are also 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.