

# Durable Power of Attorney for Health Care

(Ohio Revised Code Annotated §§ 1337.11 to 1337.17)

## NOTICE TO ADULT EXECUTING THIS DOCUMENT

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 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 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.

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 generally 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 communicate 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 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.

# Durable Power of Attorney for Health Care

1. I, \_\_\_\_\_ (print or type full name), fill out this document to set forth my treatment instructions and to designate an attorney in fact in case of my incapacity.
2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.
3. **REGARDING END-OF-LIFE MATTERS:** [initial one of the two choices]
  - (a) \_\_\_\_\_ I DO NOT WANT MY LIFE TO BE PROLONGED IF, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY, MY SITUATION IS HOPELESS. ALSO, I AUTHORIZE MY ATTORNEY IN FACT TO REFUSE OR TO WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED NUTRITION AND HYDRATION TO ME IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND MY PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR WILL NO LONGER SERVE TO PROVIDE COMFORT TO ME OR TO ALLEVIATE MY PAIN.
  - (b) \_\_\_\_\_ I WANT MY LIFE TO BE PROLONGED AS LONG AS POSSIBLE WITHIN THE LIMITS OF GENERALLY ACCEPTED MEDICAL STANDARDS, EVEN IF THIS MEANS THAT I MIGHT BE KEPT ALIVE ON MACHINES FOR YEARS.
4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. I give no one (including my attorney in fact) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.
6. Apart from the matters covered above, I designate the person named herein as my attorney in fact to make health-care decisions for me. I give my attorney in fact full power and authority to consent to or to refuse treatment on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first designated attorney in fact is unavailable, unable, or unwilling to serve, I designate an alternate attorney in fact herein to serve with the same power and authority.
7. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my attorney in fact fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my attorney in fact has the authority to make health-care decisions for me even while I am pregnant.

8. I understand the purpose and effect of this document and sign my name to this Durable Power of Attorney for Health Care on the date indicated below.

\_\_\_\_\_  
(Signature\*)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Address)

STATEMENT OF WITNESSES: I attest that the principal (the person who signed above) signed or acknowledged this Durable Power of Attorney for Health Care in my presence and 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 (1) the attorney in fact or the alternate attorney in fact designated in this document, (2) the attending physician of the principal, (3) the administrator of a nursing home in which the principal is receiving care, or (4) an adult related to the principal by blood, marriage, or adoption.**

\_\_\_\_\_  
(Signature of witness / Date)

\_\_\_\_\_  
(Signature of witness / Date)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Address)

**ATTORNEY IN FACT\***

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

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

Telephone(s): \_\_\_\_\_  
\_\_\_\_\_

**ALTERNATE ATTORNEY IN FACT\***

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

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

Telephone(s): \_\_\_\_\_  
\_\_\_\_\_

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**\* Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your attorneys in fact). You should sign this document in the presence of two witnesses. You may designate any competent adult as your attorney in fact except (1) your attending physician, (2) a nonrelative employee or agent of your attending physician, (3) the administrator of any nursing home in which you are receiving care, or (4) a nonrelative employee or agent of any health-care facility at which you are being treated. A “nonrelative” is a person not related to you by blood, marriage, or adoption.  
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**Durable Power of Attorney for Health Care**  
(signed document inside)

**NO BLOOD**

