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How to Complete Your Ohio Living Will Declaration

Living Will Declaration (R.C. 2133.02)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. An Ohio living will tells your doctors whether to withhold or withdraw life-sustaining treatment if you are in a terminal condition or permanently unconscious and cannot decide for yourself.

1. **Fill in your choices (Page 1)**
   Initial the nutrition and hydration statement only if you agree, and name anyone to be notified.
2. **Sign one of two ways (Pages 2–3)**
   Sign before **two qualified adult witnesses** (Page 2) or a **notary** (Page 3). Many people choose the notary because witnesses must meet strict rules. We can also provide witnesses for an additional fee.
3. **Donor registry (Page 3, optional)**
   Ohio requires printed living will forms to include a detachable donor registry enrollment form. Complete and send it to the BMV only if you wish to be a donor.

After It's Signed

- Give copies to your doctor, hospital, and family. Consider also an Ohio Health Care Power of Attorney. We have a free form.
- You may revoke it at any time. We have a free Ohio revocation form.

Need a Notary and Witnesses? We Come to You.

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Witnesses available for an additional fee
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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Attorneys licensed in California, Nevada, and other states.

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LIVING WILL DECLARATION

(Ohio Modified Uniform Rights of the Terminally Ill Act, R.C. 2133.01 to 2133.15)

I,

Full legal name of declarant | Date of birth

Address

being of sound mind and at least eighteen years of age, make this declaration under Ohio law, to be followed if I am unable to make informed decisions about my medical care.

1. If my attending physician and one other physician who examines me determine that I am in a **terminal condition** or a **permanently unconscious state**, and that there is no reasonable possibility that I will regain the capacity to make informed health care decisions, I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, and to provide comfort care and relief of pain.

2. **Nutrition and hydration** (initial only if you agree):

☐ **IF I AM IN A PERMANENTLY UNCONSCIOUS STATE, I AUTHORIZE MY ATTENDING PHYSICIAN TO WITHHOLD OR WITHDRAW NUTRITION AND HYDRATION, IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.**

3. **Persons to notify.** I ask my attending physician to notify the following person(s) before life-sustaining treatment is withheld or withdrawn:

Name, relationship, and telephone | Name, relationship, and telephone

4. **Other instructions** (optional):

☐ I want this declaration to also serve as my DNR identification.

Declarant's initials: _____

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Date

X

Signature of declarant

Printed name

Sign in ONE of two ways: before **two adult witnesses or** before a **notary**. Witnesses may not be related to you by blood, marriage, or adoption, and may not be your attending physician or the administrator of a nursing home where you receive care.

OPTION 1: WITNESSES.

I attest that the declarant signed or acknowledged this document in my presence, 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 related to the declarant by blood, marriage, or adoption, I am not the attending physician of the declarant, and I am not the administrator of a nursing home in which the declarant is receiving care.

X

Witness signature

Printed name

Date

Address

X

Witness signature

Printed name

Date

Address

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OPTION 2: NOTARY ACKNOWLEDGMENT

STATE OF OHIO)
) ss.
COUNTY OF)

On the date below, before me, a notary public, personally appeared the declarant named below, known to me or satisfactorily proven to be the person whose name is subscribed to this declaration, who acknowledged executing it and who appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

Name of declarant

Date

X

Notary Public

(Notary seal)

Notary's printed name

My commission expires

DONOR REGISTRY ENROLLMENT FORM (detach and send to the Ohio Bureau of Motor Vehicles; optional)

I wish to be included in the Ohio Donor Registry and make an anatomical gift, effective upon my death, of (check one):

- ☐ any needed organs, tissues, or eyes, for any purpose authorized by law
- ☐ only the following:

Organs or tissues

Full name

Date of birth

Ohio driver license / ID no.

Address

X

Signature of donor

Date

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