

SUGGESTIONS FOR PREPARING WILL TO LIVE DURABLE POWER OF ATTORNEY

*(Please read the document itself before reading this.
It will help you better understand the suggestions.)*

YOU ARE NOT REQUIRED TO FILL OUT ANY PART OF THIS "WILL TO LIVE" OR ANY OTHER DOCUMENT SUCH AS A LIVING WILL OR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. NO ONE MAY FORCE YOU TO SIGN THIS DOCUMENT OR ANY OTHER OF ITS KIND.

The Will to Live form starts from the principle that the presumption should be for life. If you sign it without writing any "SPECIAL CONDITIONS," you are giving directions to your health care provider(s) and health care agent¹ to do their best to preserve your life.

Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

If you wish to refuse some specific medical treatment, the Will to Live form provides space to do so ("SPECIAL CONDITIONS"). You may make special conditions for your treatment when your death is imminent, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably terminally ill, meaning you will live no more than three months even if given all available medical treatment. There is also space for you to write down special conditions for circumstances you describe yourself.

The important thing for you to remember if you choose to fill out any part of the "SPECIAL CONDITIONS" sections of the Will to Live is that you must be very specific in listing what treatments you do not want. Some examples of how to be specific will be given shortly, or you may ask your physician what types of treatment might be expected in your specific case.

Why is it important to be specific? Because, given the pro-euthanasia views widespread in society and particularly among many (not all) health care providers, there is great danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

Many in the medical profession as well as in the courts are now so committed to the

¹ Some states use the terms "attorney in fact," "surrogate," "designee," and "representative" instead of "agent." They are synonymous for purposes of these suggestions.

quality of life ethic that they take as a given that patients with severe disabilities are better off dead and would prefer not to receive either life-saving measures or nutrition and hydration. So pervasive is this "consensus" that it is accurate to say that in practice it is no longer true that the "presumption is for life" but rather for death. In other words, instead of assuming that a now incompetent patient would want to receive treatment and care in the absence of clear evidence to the contrary, the assumption has virtually become that since any "reasonable" person would want to exercise a "right to die," treatment and care should be withheld or withdrawn unless there is evidence to the contrary. The Will to Live is intended to maximize the chance of providing that evidence.

It is important to remember that you are writing a legal document, not holding a conversation, and not writing a moral textbook. The language you or a religious or moral leader might use in discussing what is and is not moral to refuse is, from a legal standpoint, often much too vague. Therefore, it is subject to misunderstanding or deliberate abuse.

The person you appoint as your health care agent may understand general terms in the same way you do. But remember that the person you appoint may die, or become incapacitated, or simply be unavailable when decisions must be made about your health care. If any of these happens, a court might appoint someone else you don't know in that person's place. Also remember that since the agent has to follow the instructions you write in this form, a health care provider could try to persuade a court that the agent isn't really following your wishes. A court could overrule your agent's insistence on treatment in cases in which the court interprets any vague language you put in your "Will to Live" less protectively than you meant it.

So, for example, do not simply say you don't want "extraordinary treatment." Whatever the value of that language in moral discussions, there is so much debate over what it means legally that it could be interpreted very broadly by a doctor or a court. For instance, it might be interpreted to require starving you to death when you have a disability, even if you are in no danger of death if you are fed.

For the same reason, do not use language rejecting treatment which has a phrase like "excessive pain, expense or other excessive burden." Doctors and courts may have a very different definition of what is "excessive" or a "burden" than you do. Do not use language that rejects treatment that "does not offer a reasonable hope of benefit." "Benefit" is a legally vague term. If you had a significant disability, a health care provider or court might think you would want no medical treatment at all, since many doctors and judges unfortunately believe there is no "benefit" to life with a severe disability.

What sort of language is specific enough if you wish to write exclusions? Here are some examples of things you might--or might not--want to list under one or more of the "Special Conditions" described on the form. Remember that any of these will prevent treatment ONLY under the circumstances--such as when death is imminent--described in the "Special Condition" you list it under. (The examples are not meant to be all inclusive--just samples of the type of thing you might want to write.)

"Cardiopulmonary resuscitation (CPR)." (If you would like CPR in some but not all circumstances when you are terminally ill, you should try to be still more specific: for example, you might write "CPR if cardiopulmonary arrest has been caused by my terminal illness or a complication of it." This would mean that you would still get CPR if, for example, you were the victim of smoke inhalation in a fire.) "Organ transplants." (Again, you could be still more specific, rejecting, for example, just a "heart transplant.")

"Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain, but would only keep me alive longer."

"A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me."

Pain Relief

Under the "General Presumption for Life," of your Will to Live, you will be given medication necessary to control any pain you may have "as long as the medication is not used in order to cause my death." This means that you may be given pain medication that has the secondary, but unintended, effect of shortening your life. If this is not your wish, you may want to write something like one of the following under the third set of "Special Conditions" (the section for conditions you describe yourself):

"I would like medication to relieve my pain but only to the extent the medication would not seriously threaten to shorten my life." OR

"I would like medication to relieve my pain but only to the extent it is known, to a reasonable medical certainty, that it will not shorten my life."

Think carefully about any special conditions you decide to write in your "Will to Live." You may want to show them to your intended agent and a couple of other people to see if they find them clear and if they mean the same thing to them as they mean to you. Remember that how carefully you write may literally be a matter of life or death--your own.

AFTER WRITING DOWN YOUR SPECIAL CONDITIONS, IF ANY, YOU SHOULD MARK OUT THE REST OF THE BLANK LINES LEFT ON THE FORM FOR THEM (JUST AS YOU DO AFTER WRITING OUT THE AMOUNT ON A CHECK) TO PREVENT ANY DANGER THAT SOMEBODY OTHER THAN YOU COULD WRITE IN SOMETHING ELSE.

IT IS WISE TO REVIEW YOUR WILL TO LIVE PERIODICALLY TO ENSURE THAT IT STILL GIVES THE DIRECTIONS YOU WANT FOLLOWED.

Robert Powell Center for Medical Ethics
National Right to Life
www.nrlc.org ~ (202) 378-8862

How to use the Ohio Will to Live Form

SUGGESTIONS AND REQUIREMENTS

The language of the following notice is required by Ohio Revised Code Section 1337.17 and it must be included with any pre-printed durable power of attorney for health care.

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 you could make those decisions for 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 refused 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 TO YOU COMFORT 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) 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 and 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 and 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 and 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.

- I 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.

(This ends the notice required by Revised Code Section 1337.17)

1. **IMPORTANT:** This “Will to Live” differs from many durable power of attorney forms in that it is intended for persons who generally wish to receive health care necessary to preserve their life. It includes a “General Presumption for Life” which limits the ability of the attorney in fact to refuse or withdraw informed consent to life-sustaining treatment in more situations than those statutory limitations outlined in the preceding required “Notice to Adult Executing This Document.” If you wish to give your attorney in fact authority to refuse treatment which is necessary to preserve your life in certain circumstances, you should do so in the “Special Conditions” portion of the form (see the “Suggestions for Preparing Will to Live/Durable Power of Attorney.”)
2. **Note:** Pursuant to Ohio Revised Code Section 2133.03(B)(2), if you have both a valid durable power of attorney for health care, such as this Will to Live, and a valid declaration (commonly referred to as a “living will”), the declaration supercedes the durable power of attorney to the extent that the documents would conflict in situations in which you would be in a terminal condition or in a permanently unconscious state. The provisions of Ohio Revised Code Section 2133.03(B)(2) would not apply if the declaration (or “living will”) had been revoked.
3. You may wish to give signed copies of this durable power of attorney for health care to the attorney in fact named in this document, each alternate attorney in fact, and to your lawyer, your personal physician, and members of your family.
4. The person you name as “attorney in fact” does **not** have to be a lawyer. “Attorney in fact” is simply the legal term Ohio uses for the person you want to make health care decisions on your behalf when you cannot make them for yourself.

For additional copies of the Will to Live, please visit www.nrlc.org

form prepared 2003
*clerical changes made 11/05

State of Ohio
Durable Power of Attorney for Health Care
Will to Live Form

1. DESIGNATION OF ATTORNEY IN FACT

I, (your name) _____

presently residing at

(your address) _____

(your phone number) _____

("the Principal"), being of sound mind and not under or subject to duress, fraud or undue influence, intending to create a Durable Power of Attorney for Health Care under Chapter 1337 of the Ohio Revised Code, as amended from time to time, do hereby designate and appoint:

(Name of Attorney in Fact) _____

presently residing at

(address of Attorney in Fact) _____

(phone number(s) of Attorney in Fact) _____

as my attorney in fact who shall act as my agent to make health care decisions for me as authorized in this document.

2. GENERAL STATEMENT OF AUTHORITY GRANTED

I hereby grant to my attorney in fact full power and authority to make all health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so, at any time during which my attending physician determines that I do not have the capacity to make informed health care decisions for myself. Such attorney in fact shall have the authority to give, to withdraw, or to refuse to give informed consent to any medical or nursing procedure, treatment, intervention, or other measure used to maintain, diagnose or treat my physical or mental condition. In exercising this authority, my attorney in fact shall make health care decisions that are consistent with my desires as stated in this document.

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care attorney in fact(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health-impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care attorney in fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named below, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my

health care provider(s), utilizing the most current diagnoses and/or prognoses of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

C. OTHER SPECIAL CONDITIONS:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

IF I AM PREGNANT

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

Signature of Declarant

I understand that under Ohio law as outlined in the “notice to Adult Executing This Document” accompanying this form document, I could execute a durable power of attorney for health care which would authorize my attorney in fact to refuse to give informed consent to or to withdraw informed consent to health care necessary to preserve my life in some medical situations in which this document does not authorize such a refusal or withdrawal. I have chosen to execute this document because I wish to receive health care necessary to preserve my life in accordance with the General Presumption of Life stated above, subject only to the written special conditions I have included above.

3. ADDITIONAL AUTHORITIES OF ATTORNEY IN FACT

Where necessary or desirable to implement the health care decisions that my attorney in fact is authorized to make pursuant to this document, my attorney in fact has the power and authority to do any and all of the following:

- (a) To request, review, and receive any information, verbal or written, regarding my physical or mental health, including but not limited to, all of my medical and health care facility records;
- (b) To execute on my behalf any releases or other documents that may be required in order to obtain this information;
- (c) To consent to the further disclosure of this information if necessary;
- (d) To select, employ and discharge health care personnel, such as physicians, nurses, therapists, and other medical professionals, including individuals and services providing home health care, as my attorney in fact shall determine to be appropriate;

- (e) To select and contract with any medical or health care facility on my behalf, including, but not limited to, hospitals, nursing homes, assisted residence facilities, and the like; and
- (f) To execute on my behalf any or all of the following:
 - (1) Documents that are written consents to medical treatment, or other similar orders;
 - (2) Documents that are written requests that I be transferred to another facility, written requests to be discharged against medical advice, or other similar requests; and
 - (3) Any other document necessary or desirable to implement health care decisions that my attorney in fact is authorized to make pursuant to this document.

4. DESIGNATION OF ALTERNATE ATTORNEYS IN FACT

Because I wish that an attorney in fact shall be available to exercise the authorities granted hereunder at all times, I further designate each of the following individuals to succeed to such authorities and to serve under this instrument, in the order named, if at any time the attorney in fact first named (or any alternate designee) is not readily available or is unwilling or unable to serve or to continue to serve:

First Alternate Attorney in Fact

(name) _____

presently residing at

(address) _____

 (phone number) _____

Second Alternate Attorney in Fact

(name) _____

presently residing at

(address) _____

 (phone number) _____

Each alternate shall have and exercise all of the authority conferred above.

5. NO EXPIRATION DATE

This Durable Power of Attorney for Health Care shall not be affected by my disability or by lapse of time. This Durable Power of Attorney for Health Care shall have no expiration date.

6. SEVERABILITY

Any invalid or unenforceable power, authority, or provision of this instrument shall not affect any other power, authority, or provision or the appointment of my attorney in fact to make health care decisions.

7. PRIOR DESIGNATIONS REVOKED

I hereby revoke any prior Durable Power of Attorney for Health Care executed by me.

I understand the purpose and effect of this document and sign my name to this Durable Power of Attorney for Health Care after careful deliberation.

(Signature of Principal) _____

(Date) _____

THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY TWO ELIGIBLE WITNESSES AS DEFINED BELOW WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC

WITNESSES SIGNATURE

I attest that the principal signed or acknowledged this Durable Power of Attorney for Health Care 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 the attorney in fact 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 that I am an adult not related to the principal by blood, marriage, or adoption.

First Witness Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

Second Witness Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

ALTERNATIVE TO WITNESSES

**ACKNOWLEDGMENT
NOTARY PUBLIC**

State of Ohio

County of _____

On this _____ day of _____, 20____,

before me, (name of notary public) _____
personally appeared, known to me or satisfactorily proven to be the person whose name is
subscribed to the above Durable Power of Attorney for Health Care as the principal, and
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 Seal

My Commission Expires: _____

Signature of Notary Public _____

Form prepared 1997
*clerical changes made 11/05