OHIO
STATUTORY FORM POWER OF ATTORNEY

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act (sections 1337.21 to 1337.64 of the Revised Code).

This power of attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

ACTIONS REQUIRING EXPRESS AUTHORITY

Unless expressly authorized and initialed by me in the Special Instructions, this power of attorney does not grant authority to my agent to do any of the following:

(1) Create a trust;
(2) Amend, revoke, or terminate an inter vivos trust, even if specific authority to do so is granted to the agent in the trust agreement;
(3) Make a gift;
(4) Create or change rights of survivorship;
(5) Create or change a beneficiary designation;
(6) Delegate authority granted under the power of attorney;
(7) Waive the principal's right to be a beneficiary of a joint and survivor annuity including a survivor benefit under a retirement plan;
(8) Exercise fiduciary powers that the principal has authority to delegate.

CAUTION: Granting any of the above eight powers will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I _____ (Name of Principal) name the following person as my agent:

_____

Name of Agent

_____

Agent's Address

_____

Agent's Telephone Number

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

_____

Name of Successor Agent

_____

Successor Agent's Address

_____

Successor Agent's Telephone Number

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

_____

Name of Second Successor Agent

_____

Second Successor Agent's Address

_____

Second Successor Agent's Telephone Number

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act (sections 1337.21 to 1337.64 of the Revised Code):

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

(_____) Real Property
(_____) Tangible Personal Property
(_____) Stocks and Bonds
(_____) Commodities and Options
(_____) Banks and Other Financial Institutions
(_____) Operation of Entity or Business
(_____) Insurance and Annuities
(_____) Estates, Trusts, and Other Beneficial Interests
(_____) Claims and Litigation
(_____) Personal and Family Maintenance

(_____) Benefits from Governmental Programs or Civil or Military Service
(_____) Retirement Plans
(_____) Taxes
(_____) All Preceding Subjects

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____

_____

_____

_____

_____

_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a guardian of my estate or my person, I nominate the following person(s) for appointment:

_____

Name of Nominee for Guardian of my Estate

_____

Nominee's Address

_____

Nominee's Telephone Number

_____

Name of Nominee for Guardian of my Person

_____

Nominee's Address

_____

Nominee's Telephone Number

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

_____ _____

Your Signature Date

_____

Your Name Printed

_____

Your Address

_____

Your Telephone Number

State of Ohio
County of_____

This document was acknowledged before me on _____ _____, _____ (Date), by _____ (Name of Principal).

_____

Notary

My commission expires: _____

This document prepared by: _____

IMPORTANT INFORMATION FOR AGENT

Agent's Duties

When you accept the authority granted under this power of attorney, a special legal relationship is created between you and the principal. This relationship imposes upon you legal duties that continue until you resign or the power of attorney is terminated or revoked. You must:

(1) Do what you know the principal reasonably expects you to do with the principal's property or, if you do not know the principal's expectations, act in the principal's best interest;
(2) Act in good faith;
(3) Do nothing beyond the authority granted in this power of attorney;
(4) Attempt to preserve the principal's estate plan if you know the plan and preserving the plan is consistent with the principal's best interest;
(5) Disclose your identity as an agent whenever you act for the principal by writing or printing the name of the principal and signing your own name as "agent" in the following manner:

(Principal Name) by (Agent's Name) as Agent

Unless the Special Instructions in this power of attorney state otherwise, you must also:

(1) Act loyally for the principal's benefit;
(2) Avoid conflicts that would impair your ability to act in the principal's best interest;
(3) Act with care, competence, and diligence;
(4) Keep a record of all receipts, disbursements, and transactions made on behalf of the principal;
(5) Cooperate with any person that has authority to make health-care decisions for the principal to do what you know the principal reasonably expects or, if you do not know the principal's expectations, to act in the principal's best interest.

Termination of Agent's Authority

You must stop acting on behalf of the principal if you learn of any event that terminates this power of attorney or your authority under this power of attorney. Events that terminate a power of attorney or your authority to act under a power of attorney include:

(1) The death of the principal;
(2) The principal's revocation of the power of attorney or your authority;
(3) The occurrence of a termination event stated in the power of attorney;
(4) The purpose of the power of attorney is fully accomplished;
(5) If you are married to the principal, a legal action is filed with a court to end your marriage, or for your legal separation, unless the Special Instructions in this power of attorney state that such an action will not terminate your authority.

Liability of Agent

The meaning of the authority granted to you is defined in the Uniform Power of Attorney Act (sections 1337.21 to 1337.64 of the Revised Code). If you violate the Uniform Power of Attorney Act or act outside the authority granted, you may be liable for any damages caused by your violation.

If there is anything about this document or your duties that you do not understand, you should seek legal advice.

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 health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

Agent or **attorney-in-fact** means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

Anatomical gift means a donation of all or part of a human body to take effect upon or after death.

Artificially or technologically supplied nutrition or hydration means the providing of food and fluids through intravenous or tube "feedings."

Cardiopulmonary resuscitation or **CPR** means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Ohio Hospice & Palliative Care Organization

OSMA Ohio State Medical Association

Ohio Hospital Association

Ohio Osteopathic Association

OSBA Ohio State Bar Association

Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

Donor Registry Enrollment Form means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

Do Not Resuscitate or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means this document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or **Living Will** means another document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Principal means the person signing this document.

Terminal condition or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

Naming of My Agent. 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: _____

Naming of Alternate Agents. *[Note: You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, you may wish to cross out the unused lines.]*

Should my 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:

Name: _____

Address: _____

_____

Telephone:_____

Second Alternate Agent:

Name: _____

Address: _____

_____

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.

Guidance to Agent. 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.

Authority of Agent. 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: *[Note: Cross out any authority that you do* ***not*** *want your 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 placed my initials on this line: _____**

Limitations of Agent's Authority. 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 may give additional instructions or impose additional limitations on the authority of my agent. *[Note: On the lines below you may write in additional instructions or limitations. Here you may include any specific instructions or limitations you consider appropriate, such as instructions to refuse specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. If the space below is not sufficient, you may attach additional pages. If you include additional instructions or limitations here and your wishes change, you should complete a new Health Care Power of Attorney and tell your agent about the changes. If you do not have any additional instructions or limitations, you may wish to write "None" below or cross out the unused lines.]*

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

No Expiration Date. 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.

Guardian. 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.

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

Release of Agent's Personal Liability. My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Living Will. I have completed a Living Will:_____ Yes _____ No

Anatomical Gift(s). I have made my wishes known regarding organ and tissue donation in my Living Will:_____Yes _____ No

Donor Registry Enrollment Form. I have completed the Donor Registry Enrollment Form: _____ Yes _____ No

SIGNATURE

[See next page for witness or notary requirements.]

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on _____, 20 _____, at _____, Ohio.

_____

PRINCIPAL

[You are responsible for telling members of your family and your physician about this document and the name of your agent. You also may wish, but are not required to tell your religious advisor and your lawyer that you have signed a Health Care Power of Attorney. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Health Care Power of Attorney with your county recorder for safekeeping.]

WITNESSES OR NOTARY ACKNOWLEDGMENT

[Choose one.]

[This Health Care Power of Attorney will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, ***or*** *it is acknowledged before a Notary Public.]*

[The following persons ***cannot*** *serve as a witness to this Health Care Power of Attorney: the agent; any successor agent named in this document; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]*

Witnesses. 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.

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

_____ residing at _____
Signature

_____ _____ , _____
Print Name

Dated: _____ , 20_____

OR

Notary Acknowledgment.
State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned Notary Public, personally appeared _____, 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: _____

[This notice is included in this printed form as required by Ohio Revised Code § 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.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

(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 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.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

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 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 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 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.

LIMITED POWER OF ATTORNEY

PLEASE TAKE NOTICE, that we, PARENT 1 and PARENT 2 residing at ADDRESS, effective this day of **DATE** do hereby appoint:

NAME, ADDRESS, TELEPHONE, as our attorney-in-fact, for us in our names, and for our use and benefit, and with full power to substitute at any time or times for any of the purposes described below, one or more attorneys-in-fact, and to revoke the appointment of any attorney-in-fact so substituted, and to do the following:

Grant of Limited Power

Our attorneys-in-fact may authorize **any and all medical treatment,** which may become necessary for **our child/children, NAME/S.**

This Limited Power of Attorney shall expire TIME LIMITATION from the date of execution.

Witness our signatures this day of **DATE.**

PARENT 1 PARENT 2

STATE OF OHIO)
)
COUNTY OF SUMMIT) SS.

Before me, a notary public, in and for said County, personally appeared the above named PARENT 1 AND PARENT 2, husband and wife, who acknowledged that they did sign the foregoing instrument, and that the same is their free act and deed. IN TESTIMONY WHEREOF I have hereunto set my hand and official seal, this day of **DATE.**

This instrument was prepared by:
(Attorney information)

Notary Public

State of Ohio
Living Will Declaration
Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable only to individuals in a terminal condition or a permanently unconscious state. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration controls over a Health Care Power of Attorney.

You should consider completing a new Living Will Declaration if your medical condition changes, or if you later decide to complete a Health Care Power of Attorney. If you have both documents, you should keep copies of both documents together, with your other important papers, and bring copies of both your Living Will and your Health Care Power of Attorney with you whenever you are a patient in a health care facility.

State of Ohio
Living Will Declaration
Of

_____
(Print Full Name)

_____
(Birth Date)

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.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

Anatomical gift means a donation of all or part of a human body to take effect upon or after death.

Artificially or **technologically supplied nutrition or hydration** means the providing of food and fluids through intravenous or tube "feedings."

Cardiopulmonary resuscitation or CPR means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Declarant means the person signing this document.

Donor Registry Enrollment Form means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

Do Not Resuscitate or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means another document that allows me to name an adult person to act as my agent to make health care decision for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or **Living Will** means this document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and my surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Terminal condition or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not received life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

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 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.

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, 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 want to 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: _____**

Notifications. *[Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]*

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 one of the persons named below, in the following order of priority:

[Note: If you do not name two contacts, you may wish to cross out the unused lines.]

First Contact:	Second Contact:
Name: _____	Name: _____
Address: _____	Address:
_____	_____
Telephone: _____	Telephone: _____

Anatomical Gift (optional)

Upon my death, directions regarding donation of all or part of my body are indicated on a DONOR REGISTRY ENROLLMENT FORM.

If I do not indicate a desire to donate all or part of my body by filling out a DONOR REGISTRY ENROLLMENT FORM, no presumption is created about my desire to make or refuse to make an anatomical gift.

☐ I wish to make an anatomical gift.

NOTE: If you modify or revoke your decision regarding anatomical gifts, please remember to make those changes in your Living Will, Health Care Power of Attorney, and Donor Registry Enrollment Form.

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Health Care Power of Attorney. I have completed a Health Care Power of Attorney:

_____ Yes _____ No

SIGNATURE

[See below for witness or notary requirements.]

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

Declaration on _____, 20 _____, at _____, Ohio.

_____

DECLARANT

[You are responsible for telling members of your family, the agent named in your Health Care Power of Attorney (if you have one), and your physician about this document. You also may wish to tell your religious advisor and your lawyer that you have signed a Living Will Declaration. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Living Will Declaration with your county recorder for safekeeping.]

WITNESS OR NOTARY ACKNOWLEDGMENT

[Choose one]

[This Living Will Declaration will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, ***or*** *it is acknowledged before a Notary Public.]*

[The following persons ***cannot*** *serve as a witness to this Living Will Declaration: the agent or any success or agent named in your Health Care Power of Attorney; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]*

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 of 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.

_____ residing at _____
Signature

_____ _____ ,_____
Print Name

Dated: , 20_____

_____ residing at _____
Signature

_____ _____ ,_____
Print Name

Dated: , 20_____

OR

Notary Acknowledgment.
State of Ohio
County of _____ ss.

On _____ , 20_____ , before me, the undersigned Notary Public, personally appeared _____, 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: _____

DONOR REGISTRY ENROLLMENT FORM (OPTIONAL)

_____

(name of donor)

INSTRUCTIONS:

If you have not already registered as a donor with the Ohio Bureau of Motor Vehicles when renewing a license or State ID, the "Ohio Donor Registry Enrollment Form" must be filed with the Ohio Bureau of Motor Vehicles to ensure that your wishes concerning organ and tissue donation will be honored. This document will serve as your consent to recover the organs and/or tissues indicated at the time of your death, if medically possible. In completing this form, your wishes will be recorded in the Ohio Donor Registry and will be accessible only to the appropriate organ, tissue or eye recovery organizations. Be sure to share your wishes in this area with loved ones and friends so they are aware of your intentions. The form can also be used to amend or revoke your wishes for donation.

To register for the Ohio Donor Registry, please complete this form, detach and send the original to:

Ohio Bureau of Motor Vehicles
ATTN: Record Clearance Unit
P.O. Box 16583
Columbus, Ohio 43216-6583

Make a copy of this form and retain it with other important documents such as a Living Will Declaration or Healthcare Power of Attorney. Keep these forms accessible in case of emergencies.

[This form should be used to state your intentions to be included in or removed from the Ohio Bureau of Motor Vehicles Donor Registry.]

Print or Type Full Name of Donor _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

Driver's License or ID Card Number _____

Social Security Number (optional) _____

Midwest Care Alliance
The source for home, hospice & palliative care

Ohio State Medical Association
The power of many. The voice of one.

OHIO HOSPITAL ASSOCIATION

OHIO OSTEOPATHIC ASSOCIATION

OHIO STATE BAR ASSOCIATION
EST 1880

Please select one of the following three options.

Option 1:

☐ Upon my death, I make an anatomical gift of my organs, tissues, and eyes for any purpose authorized by law.

Option 2:

☐ Upon my death, I make an anatomical gift of the following specified organ, tissues, or eyes:

☐ ALL ORGANS, TISSUES AND EYES

ORGANS:

☐ HEART

☐ LUNGS

☐ LIVER

☐ KIDNEYS

☐ PANCREAS

☐ INTESTINE/SMALL BOWEL

TISSUES:

☐ EYES/CORNEAS

☐ HEART VALVES

☐ BONE

☐ TENDONS

☐ LIGAMENTS

☐ VESSELS

☐ FASCIA

☐ SKIN

For the following purposes authorized by law:

☐ ALL PURPOSES

☐ TRANSPLANTATION

☐ THERAPY

☐ RESEARCH

☐ EDUCATION

Option 3:

☐ **Please take me out of the Organ Donor Registry.**

Signature of Donor Registrant Date Signed

HIPAA RELEASE AND AUTHORIZATION

I, CLIENTNAME, residing in CITYNAME, Ohio, authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to the agent(s) as hereinafter described, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The persons designated as my agent for purposes of this agreement are as follows:

- **CHOICE1 or CHOICE2**

The authority given my agent(s) shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164, and all other applicable state and federal law.

Signed:

_____

CLIENTNAME Date: XDATE

THE STATE OF OHIO, SUMMIT COUNTY, ss

Before me, a notary public, in and for said County, personally appeared the above named CLIENTNAME, who acknowledged that they did sign the foregoing instrument, and that the same is their free act and deed. IN TESTIMONY WHEREOF I have hereunto set my hand and official seal, this day of **XDATE**.

_____

Notary Public

DECLARATION FOR FUNERAL ARRANGEMENTS
(DISPOSITION OF BODILY REMAINS)

I,_____ of _____

_____

(legal name and present address of declarant), an adult being of sound mind, willfully and voluntarily appoint my representative, named below, to have the right of disposition, as defined in section 2108.70 of the Revised Code, for my body upon my death. All decisions made by my representative with respect to the right of disposition shall be binding.

REPRESENTATIVE:

Name(s): _____

Address(es): _____

_____

Telephone Number(s): _____

(If the representative is a group of persons, indicate the name, last known address, and telephone number of each person in the group.)

SUCCESSOR REPRESENTATIVE:

If my representative is disqualified from serving as my representative as described in section 2108.75 of the Revised Code, then I hereby appoint the following person or group of persons to serve as my successor representative.

Name(s): _____

Address(es): _____

_____

Telephone Number(s): _____

(If the successor representative is a group of persons, indicate the name, last known address, and telephone number of each person in the group.)

PREFERENCES

Preferences regarding how the right of disposition should be exercised, including any religious observances the declarant wishes a representative or a successor representative to consider: _____

_____

SOURCES OF FUNDS

One or more sources of funds that could be used to pay for goods and services associated with an exercise of the right of disposition (Representative may be entitled to reimbursement from the decedent's probate estate, ORC 2106.20): _____

EFFECTIVE:

The appointment of my representative and, if applicable, successor representative, becomes effective upon my death.

PRIOR APPOINTMENTS REVOKED:

I hereby revoke any written declaration that I executed in accordance with *section 2108.70 of the Ohio Revised Code* prior to the date of execution of this written declaration indicated below.

AUTHORIZATION TO ACT:

I hereby agree that any of the following that receives a copy of this written declaration may act under it:

-- Cemetery organization;

-- Crematory operator;

-- Business operating a columbarium;

-- Funeral director;

-- Embalmer;

-- Funeral home;

-- Any other person asked to assist with my funeral, burial, cremation, or other manner of final disposition.

MODIFICATION AND REVOCATION -- WHEN EFFECTIVE:

Any modification or revocation of this written declaration is not effective as to any party until that party receives actual notice of the modification or revocation.

LIABILITY:

No person who acts in accordance with a properly executed copy of this written declaration shall be liable for damages of any kind associated with the person's reliance on this declaration.

Signed this _____ day of _____, 20_____.

_____
(Signature of declarant)

Signature of declarant must be witnessed by 2 persons or notarized.

WITNESSES:

I attest that the declarant signed or acknowledged this assignment of the right of disposition under *section 2108.70 of the Revised Code* in my presence and that the declarant is at least eighteen years of age and 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 declarant's representative or successor representative, I am at least eighteen years of age, and I am not related to the declarant by blood, marriage, or adoption.

First witness:

_____
Name (printed)

Residing at: _____
_____

Signature:_____

Date: _____

Second witness:

_____
Name (printed)

Residing at: _____
_____

Signature:_____

Date: _____

OR

NOTARY ACKNOWLEDGMENT:

State of Ohio

County of _____ SS.

On _____, before me, the undersigned notary public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed as the declarant, and who has acknowledged that he or she executed this written declaration under section 2108.70 of the Revised Code for the purposes expressed in that section. I attest that the declarant is at least eighteen years of age and appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

_____

Signature of notary public

My commission expires on: _____

OHIO DEPARTMENT OF PUBLIC SAFETY
OHIO BUREAU OF MOTOR VEHICLES

AFFIDAVIT FOR DESIGNATION OF BENEFICIARY OR BENEFICIARIES BY THE SOLE OWNER FOR A MOTOR VEHICLE, WATERCRAFT OR OUTBOARD MOTOR CERTIFICATE OF TITLE. O.R.C. 2131.13(A)

I being first duly sworn, state as follows:

I, _____ being the sole owner of the vehicle, watercraft

or outboard motor described, Year _____ Make _____

VIN / MIN _____ Title Number _____

Do designate this vehicle, watercraft or outboard motor to:

BENEFICIARY FULL LEGAL NAME		SSN		DATE OF BIRTH
STREET ADDRESS	CITY		STATE	ZIP CODE

BENEFICIARY FULL LEGAL NAME		SSN		DATE OF BIRTH
STREET ADDRESS	CITY		STATE	ZIP CODE

BENEFICIARY FULL LEGAL NAME		SSN		DATE OF BIRTH
STREET ADDRESS	CITY		STATE	ZIP CODE

Sworn to before me in the State of _____ and county of _____

on this _____ day of _____ 20 _____.

X _____
APPLICANT / OWNER SIGNATURE

X _____ My Commission Expires on _____
NOTARY / DEPUTY SIGNATURE

The Last Will and Testament

of

TESTATOR - MOM

I, TESTATOR-MOM, being of sound and disposing mind and memory, do make, execute and publish this LAST WILL AND TESTAMENT, thus revoking all prior wills or codicils or testamentary dispositions.

ARTICLE I

I nominate and appoint my daughter, #1 Daughter, as EXECUTOR of my Will. If she is unable or unwilling to so serve, I then nominate and appoint my daughter, [ ] #2 - D, as alternate/successor EXECUTOR. It is my wish that my executor retain ATTY. NAME to serve as attorney for my estate.

ARTICLE II

Neither of my named executors shall be required to submit a bond or other security in any court or jurisdiction in which they may be called upon to act.

ARTICLE III

PROBATE COURT
COUNTY OF SUMMIT, OH
RECEIVED

I give my Executor full rights and discretions in the management and control of my [ ] real and personal, including but not limited to the following powers:

To retain any and all property and securities of my estate in the name of my executor as executor for as long as she deems advisable. To invest, lease, rent,

JILL SPICER, Judge

mortgage, insure, repair, improve or sell any and all real and personal property belonging to my estate. To enforce any and all mortgages, pledges and deeds of trust held by my estate and to purchase at any sale thereunder any real or personal property subject to such mortgage, pledge or deed of trust. TO PURCHASE FOR HERSELF any such property upon obtaining the written consents of the other beneficiaries hereunder.

To initiate or defend, at my executor's discretion, any litigation affecting my estate. To employ and to pay from estate assets reasonable compensation to such attorneys, accountants, brokers, and investment, tax and other advisors as my executor shall deem advisable.

To enforce, abandon/release (with or without compensation), defend or have adjudicated by legal proceedings, arbitration or compromise, any claim or demand of any nature which arises out of or otherwise exists in favor of or against my estate. To abandon any property, real or personal, which my Executor considers to be worthless or not of sufficient value to warrant keeping or protecting; to abstain from the payment of taxes, liens, water rents, assessments, repairs, maintenance or upkeep of any such property; to permit any such property to be lost by tax sale or other proceedings; or to convey any such property for a nominal consideration or without consideration.

To pay my just debts, funeral, and testamentary expenses, and all estate, legacy, succession and inheritance taxes that may be payable in connection with property passing upon my death; or in connection with any insurance on my life; or in connection with any gift or benefit given or provided by me either in my lifetime or by survivorship or by this Will or any Codicil hereto. Such taxes shall be charged against my residuary estate, without apportionment or proration, and with no right or reimbursement from any recipient of any property. However, any amount by which such taxes shall be increased

because of property over which I have a power of appointment or in which I have a qualifying income interest for life shall be paid by the person(s) holding or receiving such property. Interest and penalties concerning any tax shall be paid in the same manner as the tax.

To perform all other acts which my Executor considers advisable, appropriate and necessary for the efficient and proper administration of my estate.

ARTICLE IV

No Executor acting in good faith shall be liable for any loss, expense, damage, or liability to my estate occasioned by my Executor's acts or failures to act in her fiduciary capacity. My Executor shall be presumed to have acted in good faith if her action or failure to act is in reliance on a written opinion of counsel.

My Executor shall be entitled to fair and reasonable compensation for services performed, and shall be reimbursed for necessary costs and expenses incurred in administering my estate.

ARTICLE V

I give, devise and bequeath to my daughters: #2 - D, my pottery kiln; to #1-D, my father's single-shot shotgun; and for #3 - D, my doll-sized tea sets.

I purposely make no provisions for my husband, SPOUSENAME. However, should he, or anyone acting in his legal stead, elect to take a distributive share of this estate against the terms of this Will, then he shall receive only that portion to which he would statutorily be entitled at the time of such election.

ALL THE REST, REMAINDER AND RESIDUE of my estate: real, personal and intangible, I give, devise and bequeath in equal shares to my daughters #2 - D, #1 - D, and #3 - D *per stirpes*. My personal effects shall be selected by rotation, with alternating choices first by #2 -D then #1- D and then #3 - D, until all preferences have been satisfied. Any remaining items shall be sold or donated or given to a grandchild or other relative as my EXECUTOR deems advisable.

I, TESTATOR MOM, sign my name to this instrument, my Last Will Testament, on March 1, 2000. I sign willingly and as my free and voluntary act. I am an adult of sound mind and memory, and under no constraint or undue influence.

[redacted]

ATTESTATION

This Last Will and Testament of [redacted] was signed, published, and declared by her on this 1st day of MARCH, 2000. We have subscribed our names at her request, in her presence, and in the presence of each other, as witnesses to this instrument.

W [redacted]

ADDRESS

W [redacted]

ADDRESS

prepared by: [redacted]

Last Will and Testament

of

TESTATOR NAME

I , TESTATOR , now residing at _____ being of full age and sound mind and memory, do make, acknowledge, publish and declare this to be my Last Will and Testament, hereby revoking all Wills by me heretofore made.

ITEM I.

I direct that my just debts and funeral expenses be paid as soon as practicable after my decease.

ITEM II.

A. I give to my son, SON NAME . the sum of Ten Thousand Dollars ($10,000.00).

B. I give to my grandson, GRANDSON all of my tools of whatever nature and wherever situated.

C. I give to my daughter, DAUGHTER1 my home located at _____ _____ together with the contents thereof except as otherwise provided herein.

D. I give to my daughter DAUGHTER 2 my entertainment center that I built.

E. I give the rest, residue and remainder of my estate, whether real, personal or mixed, wheresoever situate, which I may own or have the right to dispose of at

the time of my decease to my daughter DAUGHTER 2 or to her lineal descendents per stirpes.

ITEM III.

I hereby nominate and appoint my daughter, DAUGHTER 2 as Executrix of this my Last Will and Testament. She is to serve without bond and shall not be required to file any inventory, appraisals or accountings, insofar as the same may be legally dispensed with. She is to have full power to sell at private or public sale, pledge, mortgage, lease, hypothecate, invest, re-invest, exchange, manage and improve, control, and in any other manner use and deal with any and all property of my estate, of every kind and description, real, personal and mixed, during its administration and to execute, acknowledge and deliver all conveyances and instruments which may be necessary or convenient to execute fully the powers conferred upon said Executor, without application to or report to any Court for leave or confirmation.

She shall have authority to distribute assets in cash or kind, or partly in cash and partly in kind, and to make a pro-rata distribution of property in kind where same may be agreed upon by the beneficiaries.

She shall have the power to do any and all things deemed by her to be desirable or essential in the administration of my estate, as fully as I could do, if living. I hereby authorize my Executrix to compound, settle and adjust all claims in favor of or against my estate.

In the event that my daughter, [ ], is unable or unwilling to serve as Executrix, then I request the Probate Court to appoint my daughter, [ ] as Alternate Executrix, with the same rights, powers and authorities as the original Executrix herein named, including the dispensation from the requirement of bond.

IN WITNESS WHEREOF, I have hereunto set my hand to this my Last Will and Testament, at the City of [redacted] State of Ohio, this 1st day of MAY, 2013.

[redacted]

[redacted]

This Instrument Prepared by:

[redacted]

LIFE ESTATE IN TANGIBLE GOODS?

Last Will and Testament

I, TESTOR MOM presently residing at

Uniontown, Ohio 44685 *County of* Summit

and State of Ohio *, being of full age and sound mind and memory, do make, publish and declare this to be my* Last Will and Testament, *hereby revoking and annulling any and all Will or Wills by me heretofore made.*

Item 1. *I direct that all my just debts and funeral expenses be paid out of my estate as soon as practicable after my decease.*

ITEM 2. I give, devise and bequeath a life estate in my real property located at PROPERTY ADDRESS, including the household goods and furniture located therein, to my daughter DAUGHTER NAME with the remainder in fee simple to my son SON NAME or to his daughter NIECE NAME in the event that my said son SON NAME has predeceased me.

ITEM 3. All the rest, residue and remainder of my estate, real and personal, of every kind and description, wheresoever located, which I may own or have a right to dispose of at the time of my decease, I give, devise and bequeath to my son SON NAME and my daughter DAUGHTER NAME, absolutely and in fee simple, share and share alike. This includes the extra lot located adjacent to my real property located at PROPERTY ADDRESS.

In the event that either of the two above named children should predecease me, it is my desire and intention that his or her share of my estate be divided equally among his or her children, then living.

In the event that either of the two above named children should predecease me without leaving issue, it is my desire and intention that his or her share of my estate shall go to the survivor of the two.

Appendix of Samples

1. **Financial Power of Attorney (a.k.a., general durable power of attorney)** – sample (Ohio Revised Code 1337.60) / eff. 3/22/2012. / Reference UNIFORM POWER OF ATTORNEY ACT 1337.21 to 1337.64

2. **Health Care Power of Attorney** - sample (Ohio Revised Code 1337.17)

3. **Limited Power of Attorney** - sample

4. **Living Will** – sample (Ohio Revised Code Section 2133)

5. **HIPAA Release Example** (Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164)

6. **Disposition of Bodily Remains Form** - Sample (Ohio Revised Code 2108.70)

7. **Ohio Bureau of Motor Vehicles Transfer on Death Form** (Ohio Revised Code Section 2131.13(A)