IOWA DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES
(Living Will)
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
(Medical Power of Attorney)

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that me life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I hereby designate _____
(Type or Print Name of Agent)

_____
(Phone Number) (Type or Print Street Address)

_____
(City) (State) (Zip Code)

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document. My agent has the right to examine my medical records and to consent to disclosure of such records.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the followings person to serve instead:

_____

(Type or Print Name of Agent)

_____

(Phone Number) (Type or Print Street Address)

_____

(City) (State) (Zip Code)

OPTIONAL: ADDITIONAL PROVISIONS – Insert here specific instructions or statement of desires (if any): _____

_____

_____

_____

_____

Signed this _____ day of _____, _____

_____
Your Signature (Declarant/Principal)

_____ _____
Street Address Type or Print Your Name

_____ _____
City State Zip Social Security Number

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC OR TWO WITNESSES.

NOTARY PUBLIC

STATE OF IOWA, _____ COUNTY, ss:
This document was acknowledged before me on _____, 20___
by _____

_____
Notary Public

WITNESSES
We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither or us is appointed as attorney in fact by this document; that neither of us are health care providers who are presently treating the Declarant/Principal, or employees of such a health care provider. We further state that we are both at least 18 years of age, and that at least on of us in not related to the Declarant/Principal by blood, marriage, or adoption.

_____ _____
Signature of First Witness Signature of Second Witness

_____ _____
Type or Print Name of Witness Type or Print Name of Witness

_____ _____
Street Address Street Address

_____ _____
City State Zip City State Zip