Iowa Durable Power of Attorney for Health Care
Will to Live Form

I, (your name)_____

(your address)_____

_____

(your phone number)_____

hereby designate:
(Name of agent)_____

(address of agent)_____

(phone number(s) of agent)_____

as my attorney-in-fact (my "agent") 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.

In the event the person I designate above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby designate the following person(s) as my attorney-in-fact (my agent) and give to my agent the power to make health care decisions for me (each to act alone and serve successively, in the order named):

A. First Successor Agent

(successor agent's name)_____

(successor agent's address)_____

_____

(successor agent's phone number)_____

B. Second Successor Agent

(second successor agent's name)_____

(second successor agent's address)_____

_____

(second successor agent's phone number)_____

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 the provisions of 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.

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 prognosis 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, (print name)_____, sign my name to this Durable Power of Attorney for Health Care on this _____ day of _____, 20_____.

(Signature)_____

FIRST ALTERNATIVE: WITNESS STATEMENT

I declare that the person who signed this document is personally known to me, that s/he signed this durable power of attorney in my presence, and that s/he appears to be of sound mind and under no duress, fraud or undue influence. I am not the person designated as attorney in fact by this document, nor am I the principal's health care provider or an employee of the principal's health care provider. I am at least eighteen years of age.

First Witness Signature:_____

Date:_____Print Name:_____

Address:_____

_____ Phone Number:_____

Second Witness Signature:_____

Date:_____Print Name:_____

Address:_____

_____ Phone Number:_____

I further declare that I am not a relative of the principal by blood, marriage, or adoption (within the third degree of consanguinity).

_____
(signature of first OR second witness

SECOND ALTERNATIVE: NOTARIZATION

State of Iowa)
) ss
County of _____)

Signed and sworn to before me by_____,

this _____ day of _____, 20____.

_____
Signature of Notary Public

OPTIONAL (BUT RECOMMENDED)

I state that the person this document designates as my attorney in fact (my agent) to make health care decisions for me has been notified of and has consented to the designation.

_____
Signature of Principal

form prepared 2001
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