DURABLE POWER OF ATTORNEY FOR HEALTH CARE

FOR

Name: ____

CHRISTIAN AFFIRMATION OF LIFE

Life is a gift of God which I treasure and wish to live to the fullest. As a person created by God and in God's image, I have dignity and value. My life has been given to me as a sacred trust. I do not have absolute dominion over it but need to take reasonable care of it.

As a Christian, I believe that death is part of life, that through death life is changed, not taken away, and that death need not be resisted by every possible means. By not unduly prolonging life, I can attest to my belief in eternal life.

I am free legally and morally to choose the course of treatment that is best for me, taking into consideration the benefits to be gained, the burdens to me or to others and the risks involved for each treatment.

Since I cannot foresee situations that may arise in regard to my health, I am choosing an agent who knows me and who can speak on my behalf should I become incapable of making my own decisions.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, the Principal, hereby

Designate ____

First Name Last Name

____

(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. In the event of a conflict between written and oral directives, the last statement made by me while competent, whether written or oral, shall take precedence. If it is not clear what I would want done, my attorney in fact should make decisions for me that s/he judges to be in my best interests, in accord with the moral teachings of the Catholic Church.

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.

I hereby revoke all prior Durable Powers of Attorney for Health Care.

SPECIFIC INSTRUCTIONS AND STATEMENT OF DESIRES

Insert here specific instructions or statement of desires of principal (if any). Additional sheets may be attached. NOTE: The Principal does not have to give any specific instructions or statement of desires but may do so.

DESIGNATION OF ALTERNATE HEALTH CARE AGENT

NOTE: The Principal may designate one or more alternates as attorney in fact but does not have to do so.

If the person designated above is unable to serve,

I designate ____

(Type or print) First Name Last Name

____

(Type or Print) Street Address City State Zip Code

to serve as my attorney in fact.

Signed this__________day of ______________ , 20____.

Signature of Principal (Person Granting the Power of Attorney)

____

Type or Print Name of Principal

____

Street Address

____

City State Zip Code

____

This Power of Attorney must either be witnessed by two persons OR notarized.

NOTARY PUBLIC

STATE OF IOWA,__________________________________County, ss:

On this_____ day of ______________ , A.D. 20___. before me, the undersigned, a Notary Public in and for the State of Iowa, personally appeared

to me known to be the person named in and who executed the foregoing instrument, and acknowledged that (he)(she) executed the same as (his)(her) voluntary act and deed.

Notary Public in and for the said State.

OR

STATEMENT OF TWO WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her signing of this power of attorney is voluntary. I am at least 18 years of age. I am not a health care provider for the principal at this time

______________________________	______________________________
Signature of 1st Witness	Signature of 2nd Witness
______________________________	______________________________
Type or Print Name of Witness	Type or Print Name of Witness
______________________________	______________________________
Street Address	Street Address
______________________________	______________________________
City State Zip Code	City State Zip Code

This is a legal document. Although it can be completed without a lawyer, do not sign itunless you clearly understand what it means. You may want to consult a lawyer if you have anyquestions.

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Archdiocese of Dubuque
Dubuque, Iowa

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OPTIONAL ADDENDUM

SPECIFIC DIRECTIVES FOR HEALTH CARE DECISIONS

Complete the categories and specific directives for which you would like to give instructions to your agent. You have the option of leaving categories blank and leaving choices between specific directives blank. Be sure the various instructions you give are consistent with each other.

Categories include:

- *chronic and/or progressively debilitating condition*
- *terminal condition*
- *imminent death*

Directives are specifically provided for:

- *cardio -pulmonary resuscitation*
- *assisted nutrition and hydration*
- *other types of health care interventions*
- *pain management.*

The generic term "health care interventions" refers to (but is not limited to) such procedures as use of antibiotics and other medications, being placed on a ventilator, surgery, blood transfusions, kidney dialysis, and chemotherapy. It includes decisions about whether to be hospitalized and about the level of critical care within a hospital.

MY WISHES

Section (I)

I am suffering from a serious chronic condition and/or I am becoming progressively debilitated. [For example: Parkinson's disease, Alzheimer's disease and other dementias, debilitation of advanced age, state of prolonged unconsciousness (e.g., persistent/permanent vegetative state).]

(1) Cardio-pulmonary resuscitation

_____ I do not want cardio-pulmonary resuscitation if my heart stops or I stop breathing as part of the natural dying process.

OR

_____ I want cardio-pulmonary resuscitation.

(2) Assisted nutrition and hydration (tube feeding)

_____ Assisted nutrition and hydration should be used when I have need of it. However, I want assisted nutrition and hydration withheld or withdrawn if it cannot reasonably be expected to prolong my life or if it would be excessively burdensome for me or if it would cause me significant physical discomfort.

OR

_____ I want assisted nutrition and hydration used indefinitely when I have need of it, provided it will succeed in providing nourishment to my body.

(3) Other types of health care interventions

____ I want other types of health care interventions which offer a reasonable hope of benefitting my health and/or contribute to my comfort. I do not want health care interventions which are not likely to be beneficial to me, and I do not want health care interventions which are excessively burdensome. If a health care intervention has been started which proves not to be beneficial or is excessively burdensome, I want it stopped.

OR

_____ I want all available health care interventions used to try to treat my condition.

(4) Pain management

_____ I want my caregivers to relieve my pain as much as possible even if it means that I will be drowsy or sleep more than I would otherwise or experience decreased mental lucidity, if this is the only way to relieve my pain and I have had the opportunity to carry out my duties in my relationships with others and to prepare spiritually for death.

OR

_____ I want my caregivers to relieve my pain but I also want to remain awake and as alert as possible even though I may still have some degree of pain and discomfort. However, if the pain becomes severe, I am willing to accept being drowsy or sleeping more than I would otherwise or having decreased mental lucidity if this is the only way to relieve my pain and I have had the opportunity to carry out my duties in my relationships with others and to prepare spiritually for death.

OR

_____ I want my caregivers to relieve my pain but I always want to remain awake and as alert as possible even though I may still have some pain and discomfort.

Section (II)

I have a terminal illness, that is, I have an incurable or irreversible condition that will eventually lead to my death. [For example: cancer that has become incurable.]

(1) Cardio-pulmonary resuscitation

_____ I do not want cardio-pulmonary resuscitation if my heart stops or I stop breathing as part of the natural dying process.

OR

_____ I want cardio-pulmonary resuscitation.

(2) Assisted nutrition and hydration (tube feeding)

_____ Assisted nutrition and hydration should be used when I have need of it. However, I want assisted nutrition and hydration withheld or withdrawn if it cannot reasonably be expected to prolong my life or if it would be excessively burdensome for me or if it would cause me significant physical discomfort.

OR

_____ I want assisted nutrition and hydration used indefinitely when I have need of it, provided it will succeed in providing nourishment to my body.

(3) Other types of health care interventions

____ I want other types of health care interventions which offer a reasonable hope of benefitting my health and/or contribute to my comfort. I do not want health care interventions which are not likely to be beneficial to me, and I do not want health care interventions which are excessively burdensome. If a health care intervention has been started which proves not to be beneficial or is excessively burdensome, I want it stopped.

OR

_____ I want all available health care interventions used to try to treat my condition.

(4) Pain management

_____ I want my caregivers to relieve my pain as much as possible even if it means that I will be drowsy or sleep more than I would otherwise or experience decreased mental lucidity, if this is the only way to relieve my pain and I have had the opportunity to carry out my duties in my relationships with others and to prepare spiritually for death.

OR

_____ I want my caregivers to relieve my pain but I also want to remain awake and as alert as possible even though I may still have some degree of pain and discomfort. However, if

the pain becomes severe, I am willing to accept being drowsy or sleeping more than I would otherwise or having decreased mental lucidity if this is the only way to relieve my pain and I have had the opportunity to carry out my duties in my relationships with others and to prepare spiritually for death.

OR

_____ I want my caregivers to relieve my pain but I always want to remain awake and as alert as possible even though I may still have some pain and discomfort.

* * * * *

Section (III)

My death is imminent, that is, I have an incurable or irreversible condition that is expected to cause my death within a relatively short period of time.

(1) Cardio-pulmonary resuscitation

_____ I do not want cardio-pulmonary resuscitation if my heart stops or I stop breathing as part of the natural dying process.

OR

_____ I want cardio-pulmonary resuscitation.

(2) Assisted nutrition and hydration (tube feeding)

_____ I am willing to forgo assisted nutrition and hydration as it is not likely to prolong my life or provide comfort.

OR

_____ I want assisted nutrition and hydration used until the time of my death, provided it will succeed in providing nourishment to my body.

(3) Other types of health care interventions

_____ I want to be kept comfortable and to allow natural death to occur. I do not want any other types of health care interventions used to try to extend my life. If life-prolonging treatments have been started, I want them stopped.

OR

_____ I want all available health care interventions used that might delay my death and extend my life for as long as possible.

(4) Pain management

_____ I want my caregivers to relieve my pain as much as possible even if it means that I will be drowsy or sleep more than I would otherwise or experience decreased mental lucidity, if this is the only way to relieve my pain and I have had the opportunity to carry out my duties in my relationships with others and to prepare spiritually for death. If I am experiencing extreme, intractable pain, I may be sedated to the point of unconsciousness as a last resort.

OR

_____ I want my caregivers to relieve my pain but I also want to remain awake and as alert as possible even though I may still have some degree of pain and discomfort. However, if the pain becomes severe, I am willing to accept being drowsy or sleeping more than I would otherwise or having decreased mental lucidity if this is the only way to relieve my pain and I have had the opportunity to carry out my duties in my relationships with others and to prepare spiritually for death. If I am experiencing extreme, intractable pain, I may be sedated to the point of unconsciousness as a last resort.

OR

_____ I want my caregivers to relieve my pain but I always want to remain awake and as alert as possible even though I may still have some pain and discomfort.

* * * * *

SECTION (IV)

ADDITIONAL DIRECTIVES:

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Dubuque, Iowa

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GENERAL INFORMATION ON THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

LEGAL INFORMATION

A durable power of attorney for health care is subject to the provisions of Chapter 144B of the Code of Iowa and reference should be made to that chapter. The following is a summary of some of the provisions of Chapter 144B of the Code of Iowa.

1. **Definition of "Health Care" and "Health Care Provider"**
   An attorney in fact (agent) has the power to make decisions about "health care," meaning any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. This includes the provision of nutrition or hydration only when they are provided intravenously or through a tube feeding. "Health care provider" means a person or health care facility licensed or certified to administer health care in the ordinary course of business or practice of a profession.

2. **Witnessing**
   Witnessing maybe done in two ways: A Notary Public OR Two Witnesses.

   a. The following individuals shall not be witnesses for a durable power of attorney for health care:
      1) A health care provider attending the principal (signer) on the date of the signing of this document.

      2) An employee of a health care provider attending the principal on the date of the signing of this document.

      3) The individual designated in the durable power of attorney for health care as the attorney in fact (your agent).

      4) An individual who is less than eighteen years of age.

   b. One of the witnesses shall be an individual who is not a relative of the principal by blood, marriage, or adoption within the third degree of blood relationship.

3. **Attorney in fact (the agent designated as proxy decision maker)**
   The following individuals shall not be designated as the attorney in fact (agent) to make health care decisions under a durable power of attorney for health care:

   a. A health care provider attending the principal (signer) on the date of signing.

   b. An employee of a health care provider attending the principal on the date of signing unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of blood relationship.

Although there is no legal requirement to do so, it is advisable for the principal to ask the individual s/he wishes to designate as the attorney in fact (agent) about his/her willingness to serve in this capacity before executing the durable power of attorney for health care.

4. **Revocation**
   a. A durable power of attorney for health care may be revoked at any time and in any manner by which the principal is able to communicate the intent to revoke, without regard to mental or physical condition.

   b. Revocation may be made by notifying the attorney in fact (agent) orally or in writing. See also (d) below.

   c. Revocation can also be made by notifying a health care provider orally or in writing while that provider is engaged in providing health care to the principal.

   d. A revocation is only effective as to a health care provider upon its communication to the provider by the principal or by another to whom the principal has communicated revocation.

   e. The health care provider is required to document the revocation in the treatment records of the principal.

   f. The principal is presumed to have the capacity to revoke a durable power of attorney for health care.

   g. Unless it provides otherwise, a valid durable power of attorney for health care revokes any prior durable power of attorney for health care.

5. **Prohibited Practices**
   a. A health care provider, health care service plan, insurer, self-insured employee welfare benefit plan, or nonprofit hospital plan shall not condition admission to a facility, or the providing of treatment, or insurance, on the requirement that an individual execute a durable power of attorney for health care.

   b. A policy of life insurance shall not be legally impaired or invalidated in any manner by the withholding or withdrawing of health care pursuant to the direction of an attorney in fact appointed pursuant to this chapter.

6. **Notification**
   It is the responsibility of the principal to notify the health care provider of the terms of the durable power of attorney for health care.

   When the document has been signed, it is advisable (although not legally required) to notify the attorney in fact (agent) that the document has been executed.

INFORMATION REGARDING SPECIFIC INSTRUCTIONS AND STATEMENT OF DESIRES

Completing this section of the form is optional. The principal may document in writing wishes and instructions regarding medical treatments which will guide and legally bind his/her agent.

Examples of specific instructions which may be given are found in the **Optional Addendum Specific Directives for Health Care Decisions.** These directives are formulated in accord with the moral teachings of the Catholic Church.

In this section of the document the principal may make provision for organ donation, or include stipulations of a specifically religious character (e.g., If at all possible, I wish to receive the sacraments before my death).

When executing a durable power of attorney for health care, an individual cannot foresee and take into account all the specific and particular conditions which may hold when the document takes effect. Thus it is prudent to leave room for the agent to exercise his/her discretion about medical treatments. Written instructions, whether general or specific, may also be used as a way of assuring healthcare providers and others that decisions likely to be made by the agent are in fact in accord with the wishes and desires of the principal.

SUGGESTIONS AFTER THE FORM IS PROPERLY SIGNED AND WITNESSED OR NOTARIZED

It would be well to place the original in a safe place known and accessible to family members or close friends.

Give copies of the original to your physician, your agent and alternates, and family members.

Discuss with your physician and agent your values and wishes that can be used as guidelines to fulfill your expectations as closely as possible.

Note:
This document is more comprehensive than a living will. While a living will becomes effective only when the principal is incapable of making health care decisions and is terminally ill or permanently unconscious, the durable power of attorney for health care becomes effective whenever the principal becomes incapacitated to make his/her own decisions.

Revised November 2010