I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

If I should have an incurable 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 my 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 the "Situational Decisions" section below.

II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I hereby designate (name) ____,
(street address, city, state, zip code)____,
(telephone number, home, cell and work) ____________________________________ as my attorney (attorneys) in fact (my agent) and give to my agent the power to make health care decisions for me.

If the person(s) designated above is unable to serve,
I designate in order of preference as numbered (name/s) ___________________________________
____,
(street address, city, state, zip code) ____
____,
(telephone number, home, cell and work) ____,
to serve as my attorney (attorneys) in fact.

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.

I hereby relieve any hospital, nursing home or health facility in which I may be at the time of my illness, and their employees and/or staff, from any and all responsibility in the action or lack of action of any physician acting according to my direction in this regard. I hereby absolve my next of kin, my attorney for health care, and my physician, or any physician taking care of me, from any legal liability pertaining to the fulfillment of my wishes in this regard. If any action is taken contrary to my directives in this document, I hereby request my next of kin or legal representative, if necessary to take legal actions against any of those involved who are aware of, but disregard this document. If any of my next of kin oppose this directive, their opposition is to be considered without legal grounds, since I remove any right of my next of kin who oppose me in this directive to speak for me.

SITUATIONAL DECISIONS

(The Principal does not have to give any specific instructions, but may choose to do so. The Principal may choose 1 and/or 2 of the situational decisions below by initialing the choices and chart below each choice or by giving specific instructions or statements below.)

________ (Initials) If the situation should arise in which there is no reasonable expectation of my recovery from a disability, illness, or accident which renders me incapable of comprehending my surroundings and/or recognizing and interacting with members of my family (for example; prolonged coma, severe dementia, or a permanent vegetative state), I want to be allowed to die, and not be kept alive by artificial means or heroic measures, including the provision of artificial nourishment and artificial hydration and any medical or surgical treatment which would prolong my life under such circumstances.

	ADMINISTER	WITHHOLD	I GIVE MY AGENT FULL DISCRETION
Surgery (for example, hip, removing the gall bladder, or part of the colon)			
Respiratory Support (respiration by a machine or through a tube in the throat)			
Dialysis (cleaning the blood by machine or by fluid passed through the belly)			
Antibiotics (oral or intravenous in a vein)			
Cardiac Resuscitation (an attempt to restart the heart using chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying)			
Blood Test			
X-Rays			
Transfusions			
Non-Orally Ingested Nutrition (tube feeding through the nasal passage or through the wall of the abdomen into the stomach or surgically into the small intestine)			
Non-Orally Ingested Hydration (intravenous feedings in a vein))			
XXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXXXXXX
I Want Comfort Care Only As Primary Treatment (relieving suffering and controlling pain)			

- AND/OR –

________ (Initials) If, in the opinion of two physicians, I have an incurable chronic illness (for example, mild, but progressive dementia, cancer metastasized to the brain) that involves mental disability and physical suffering and ultimately causes death, and in addition I have an illness that is immediately life threatening, but reversible (for example, bowel obstruction, fractured hip, pneumonia, urinary tract infection), and I am temporarily unable to make decisions, than my wishes are indicated in the chart below.

	ADMINISTER	WITHHOLD	I GIVE MY AGENT FULL DISCRETION
Surgery (for example, hip, removing the gall bladder, or part of the colon)			
Respiratory Support (respiration by a machine or through a tube in the throat)			
Dialysis (cleaning the blood by machine or by fluid passed through the belly)			
Antibiotics (oral or intravenous in a vein)			
Cardiac Resuscitation (an attempt to restart the heart using chest compressions, drugs, electric shocks, and artificial breathing aimed at reviving a person who is on the point of dying)			
Blood Test			
X-Rays			
Transfusions			
Non-Orally Ingested Nutrition (tube feeding through the nasal passage or through the wall of the abdomen into the stomach or surgically into the small intestine)			
Non-Orally Ingested Hydration (intravenous feedings in a vein))			
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXXXXXXXX
I Want Comfort Care Only As Primary Treatment (relieving suffering and controlling pain)			

- AND/OR -

NOTE: Write specific instructions or statements of desires regarding health care (optional);

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

I, ________________________________, the principal, sign my name to this instrument this ____ day of ______________, 200__, and being first duly sworn, do hereby declare to the undersigned that I am eighteen years of age or older, of sound mind, and under no undue constraint or influence.

______________________________________ ______________________
(Principal) (Date of Birth)

We, the undersigned, herby state that we signed this document in the presence of each other and the Principal and we witnessed the signing of the document by the Principal or by another person acting on behalf of the Principal at the direction of the Principal; that neither of us is appointed as attorney in fact by this document; that neither of us are health care providers who are presently treating the 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 one of us is not related to the Principal by blood, marriage or adoption.

Witness #1
Signature _____________________________
Print Name_____________________________
Address and Telephone Number ____
Date __________________________________

Witness #2
Signature _____________________________
Print Name ____________________________
Address and Telephone Number ____
Date __________________________________

- OR -

Notary Public
The State of Iowa)
)ss.
The County of _________)
Signed and sworn to before me by ________________________________, the principal, this ______ day of __________________, 200__

(SEAL)

____
(Notary Public)

General Information Regarding This Document

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Life-sustaining procedure" means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, wand when applied to a person in a terminal condition, would serve to only prolong the dying process. "Life sustaining procedure" does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

2. The terms "health care" and life-sustaining procedure "include nutrition and hydration (food and water) only when provided parenterally (other than through the intestines) or through intubation (intravenously or by feeding tube). Thus, this document authorizes withholding nutrition or hydration that is provided intravenously or by feeding tube. If this is not what you want, you need to set forth your specific instructions in "Situational Decisions" on page 2-4 and also, if needed, in each chart following each "Situation Decision".

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

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

4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining procedures 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 physical condition. A revocation is only effective as to the attending health care provider upon its communication to the provider by the principal by another to whom the principal has communicated the revocation.

5. It is the responsibility of the principal to provide the attending health care provider with a copy of this document.

6. A declaration relating to use of life-sustaining procedures will be given effect only when the principal's condition is determined to be terminal or the principal is in a state of permanent unconsciousness, and the principal is not able to make treatment decisions.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTORIZED

1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a copy to your doctor and health care provider.
3. Provide a copy(s) to family member(s).
4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).