**SUGGESTIONS & REQUIREMENTS**

**For Medical Power of Attorney & Completing the Iowa Will to Live Form**

1. This Medical Power of Attorney (also known as the Health Care Agent Designation Form) allows you to designate a health care agent who will make health care decisions for you whenever you are unable to make them for yourself; these forms allow you to direct your medical care through your health care agent. Any person who is at least 18 years old may designate a health care agent through this document.

2. Carefully read the “Information Concerning the Medical Power of Attorney.” Sign and date the form to show you have done so. This form explains the witnessing requirements and eligibility restrictions for your health care agent.

3. You must sign this Medical Power of Attorney either in the presence of two witnesses (who must also sign the document) or in the presence of a Notary Public (who also must sign as Notary). Iowa Code section 144B.3. Each witness must be a competent adult (18 years of age or older), and at least one of the witnesses must be a person who is NOT a person related to you by blood, marriage, or adoption within the third degree of consanguinity, to wit: a niece, nephew, aunt, uncle, great grandparent, or great grandchild.

 Nor shall any of the following persons be a witness:

a. your attending physician,

b. an employee of your attending physician, or

c. a minor, whether or not related to you.

 In addition, the following persons probably should not be asked to serve as witnesses, due to potential

 conflicts of interest:

 d. a person entitled to receive from you any part of your estate after your death under a will or

 codicil executed by you or by operation of law, if you should depart this life;

e. an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you,

f. an officer, director, partner, or business office employee of the health care facility or parent organization of the health care facility providing care to you, or

g. a person who, at the time this Medical Power of Attorney is executed, has a claim against any part of your estate after your death.

4. An alternate health care agent(s) should be designated who can to take over if your first designee is unable to serve. Space is provided on the form for this alternate designation. The same rules apply to the alternate health care agent as for the primary health care agent.

6. If you physically cannot sign this document, another person may sign your name for you at your express direction in your presence and in the presence of your two witnesses.

7. Tell your physician and your attorney at law about this document. Also ask your physician to keep a copy of this document as a part of your medical health record. Your attorney may keep a copy also.

8. This type of document has been authorized by the “Life Sustaining Procedures Act” published in Title IV of

 the Iowa Code at Chapter 144A, and also the Durable Power of Attorney for Health Care statute, Code

 Chapter 144B.

9. If you have any questions about this document, or want assistance in completing it, please consult an attorney.

**Information Concerning the Medical Power of Attorney and the Iowa Will to Live**

**THIS IS AN IMPORTANT LEGAL DOCUMENT.**

**BEFORE SIGNING THIS DOCUMENT, LEARN THE FOLLOWING IMPORTANT FACTS.**

Except to the extent you state otherwise, this document authorizes the person you name as your health care agent to make any and all health care decisions for you in accordance with your advance instructions when you can no longer make such decisions for yourself. These instructions should incorporate your religious and

moral beliefs. Because “health care” means any treatment, service, or procedure to maintain, diagnose or treat

your physical or mental condition, your health care agent has the power to make a broad range of health care decisions for you. Your health care agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your health care agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion.

Iowa Code section 144A.7 allows a physician or hospital to withdraw “life-sustaining procedures” from you. Such procedures include food and water and pain medication if circumstances require their provision parenterally or through a feeding tube. Such undesired actions might occur despite your expressed instructions in a validly executed medical power of attorney. However, if your instructions are written and clearly expressed in a “Medical Power of Attorney” accompanied by a completed “Will to Live” document, your health care agent will be in a better position to defend your life in the event the agent needs to go to court to protect your life from the withdrawal or denial of medical treatment and/or food and fluids.

Your health care agent’s authority begins when your doctor certifies in writing that you lack the competence to make health care decisions. Iowa Code section 144B.5. Your health care agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your health care agent has the same authority to make decisions about your health care that you would have if you were competent.

Your instructions and this document should be discussed with your health care agent, physician, other health care provider(s) if any, and your family before you sign it, thereby ensuring that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, consult with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything that you do not understand in this document, consult an attorney.

The person you appoint as your health care agent should be someone you know and trust. The person must be

18 years of age or older or a person under 18 years of age who has had the disabilities of minority legally removed. No person serving you as attending physician or health care provider on the date you sign this Power of Attorney may serve as your attorney in fact. Nor may any person serving as employee of such health care provider, as of the date of your signing this Power of Attorney, also serve as your agent for health care decision making, unless that person is directly related to you by blood, marriage, or adoption within the third degree of consanguinity. Iowa Code section 144B.4.

The disclosure statements given in the first three pages of this should be taken as illustrating legal principles of general applicability. If you have particular needs or questions about your own circumstances then please do consult with your personal attorney at law.

Inform the person who you appoint that you want the person to be your health care agent. Discuss your instructions and this document with your health care agent in addition to your physician and give each a signed copy. The document itself should indicate the institutions and people who are in possession of signed copies.

Your health care agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so. You have the right to revoke the authority granted to your health care agent by informing your health care agent or your health or residential care provider orally or in writing or by execution of a subsequent Medical Power of Attorney. Iowa Code section 144B.8. Be aware that your appointment of a spouse as agent does not necessarily cease upon the court’s issuing a decree of divorce, unless you so specify.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate health care agent in the event that your health care agent is unwilling, unable, or ineligible to act as your health care agent. Any alternate health care agent you designate has the same authority to make health care decisions for you.

THIS MEDICAL POWER OF ATTORNEY IS NOT VALID UNLESS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. AT LEAST ONE OF THE WITNESSES MUST BE UNRELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION WITHIN THIRD DEGREE OF CONSANGUINITY. NEITHER YOUR HEALTH CARE PROVIDER NOR HIS EMPLOYEES MAY SERVE AS WITNESSES.

I have read and understood the contents of this disclosure statement.

(Signature)

Signed this \_\_\_\_\_\_ day of the month of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Anno Domini 20 \_\_\_\_\_.

**MEDICAL POWER OF ATTORNEY**

**and IOWA WILL TO LIVE**

 Pursuant to Iowa Code Chapters 144A and 144B, and specifically under power of section 144A.3 and 144B.5:

I (name)

Residing at (mailing address):

 Reachable by telephone number ( )

Do hereby designate

(Name of health care agent & relation to you)

Residing at (mailing address):

Reachable by telephone number(s) ( )

as my attorney in fact and health care agent. I give to my agent the power to make any and all health care decisions for me, except to the extent I state otherwise in this document. Said power exists, and this Medical Power of Attorney takes effect, only when, in the judgment of my attending physician, I am unable to make my own health care decisions and this fact is certified in writing by my attending physician. My attorney in fact must act consistently with my desires as stated in this document. Should my attorney in fact attempt to do any act contrary to the desires stated herein then the power herein granted automatically terminates.

**I HEREBY LIMIT DECISION MAKING AUTHORITY OF MY HEALTH CARE AGENT.**

**GENERAL PRESUMPTION FOR LIFE**

I direct my health care provider(s) and health care agent(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 agent 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 contribute to, hasten, or cause my death. I direct that the following be provided to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions:

a) the administration of medication,

b) cardiopulmonary resuscitation (CPR), and

c) the performance of all other medical procedures, techniques, and technologies, including surgery.

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 when the procurement of such tissue or organ would cause, contribute to, or hasten that person’s death, including stem cells extracted from human embryos, or stem cells 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 agent to follow the policy above, even if I am judged to be incompetent.

Nothing in this Medical Power of Attorney and Iowa Will to Live shall be interpreted to release from liability any medical practitioner or other individuals, partners or corporations providing me health service which is contrary to my expressed instructions a) as directed by me herein, or b) directed by my health care agent pursuant to this Power of Attorney, and which causes me any injury or death.

During the time I am incompetent, my health care agent, as named above, 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 a reasonably prudent physician, knowledgeable about my case and treatment possibilities with respect to the medical conditions involved, would judge that I have an incurable terminal illness or injury, and I will die imminently even if lifesaving treatment or care is provided to me, the following medical goods and/or services may be withheld or withdrawn from me:

**(Be as specific as possible.) If nothing is listed then all necessary goods and services shall be provided.**

(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 my case and 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 medical goods and/or services may be withheld or withdrawn from me:

**(Be as specific as possible.) If nothing is listed then all necessary goods and services shall be provided.**

(Cross off any remaining blank lines.)

**C. OTHER SPECIAL CONDITIONS**

**(Be as specific as possible.)**

(Cross off any remaining blank lines.)

**D. Special Instructions for Pregnancy (Applies only if this paragraph is separately signed by principal.)**

If I am pregnant, I direct my health care provider(s) and health care agent(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

**DESIGNATION OF ALTERNATE HEALTH CARE AGENT**

*(You are not required to designate an alternate health care agent, but doing so can be helpful. An alternate health care agent may make the same health care decisions as the designated health care agent if the designated health care agent is unable or unwilling to act as your health care agent. If the health care agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)*

If the person designated as my health care agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my health care agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Health Care Agent

(Name of agent and relation)

(Address)

(Telephone Number)

B. Second Alternate Health Care Agent

(Name of agent and relation to you)

(Address)

(Telephone Number)

The original of this document is kept at the following location:

**DURATION**

I understand that this Medical Power of Attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke this Medical Power of Attorney. If I am unable to make health care decisions for myself when this document expires, the authority granted to my health care agent lasts until the time I become able to make health care decisions for myself. (IF APPLICABLE) This Medical Power of Attorney ends on the following date:

**PRIOR DESIGNATIONS REVOKED**

I revoke any and all Medical Powers of Attorney, designations of Health Care Agent, and Declarations as to life sustaining procedures that I may have executed prior to signing this document.

**ACKNOWLEDGMENT OF DISCLOSURE STATEMENT**

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

**(YOU MUST DATE AND SIGN THIS MEDICAL POWER OF ATTORNEY.)**

I Sign My Name to this Medical Power of Attorney on this Day of , 20

at (City, State).

(Your Signature)

(Your Printed Name)

**NOTARY PUBLIC ACKNOWLEDGMENT**

Subscribed and sworn to before me this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ A.D. 20\_\_\_\_\_, by the principal herein as said principal’s voluntary act and deed.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NOTARY PUBLIC IN AND FOR THE STATE OF IOWA

**STATEMENT OF WITNESSES**

I am a legal adult. I am not the person appointed as health care agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

First Witness Signature:

Name:

Date:

Residential Address:

Second Witness Signature:

Name:

Date:

Residential Address: