

# Iowa Durable Power of Attorney for Health Care

## Will To Live Form

I, \_\_\_\_\_, (the "Principal")

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

*(print or type, Name, Address, Phone Number to the right)*

Hereby designate, \_\_\_\_\_, (the "Agent")

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

*(print or type, Name, Address, Phone Number to the right)*

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): (First and Second Alternate Agents) *(Optional)*

Hereby designate, \_\_\_\_\_,

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

*(print or type, Name, Address, Phone Number to the right)*

Hereby designate, \_\_\_\_\_,

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

*(print or type, Name, Address, Phone Number to the right)*

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 provision 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 (agent) 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, or 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 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.

The instructions in this document are intended to be followed even if suicide is alleged to be attempted at some point after it is signed.

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 above policy, even if I am judged to be incompetent.

During the time I am incompetent, my 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 conditions.

**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:

Nothing shall be withdrawn or withheld without agreement from myself or my agent.

**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:

Nothing shall be withdrawn or withheld without agreement from myself or my agent.

**OTHER SPECIAL CONDITIONS:**

C. It is the intention of the Principal to aggressively seek treatment for any and all medical conditions that arise.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature (Person Granting the Power of Attorney)

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

*(print or type, Name, Address, Phone Number to the right)*

STATE OF IOWA, \_\_\_\_\_ COUNTY, ss:

On this \_\_\_\_ day of \_\_\_\_\_, 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 executed the same as his voluntary act and deed.

\_\_\_\_\_  
Notary Public in and for said State