Regional Medical Center
Manchester, Iowa

ADVANCE DIRECTIVES FOR HEALTHCARE

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES (LIVING WILL)

If I should have an incurable or 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 healthcare decisions, I direct my attending physician to withhold or withdraw treatment that only prolongs my dying. I instruct that my treatment consist of measures to keep me comfortable and to relieve pain.
I have strong beliefs about the following forms of treatment:

Check those statements that you agree with:
___I do not want cardiac resuscitation (CPR).
___I do not want mechanical ventilation (respirator).
___I do not want artificial nutrition and hydration (intravenous fluids or feeding tube).
___I do not want medical treatment (antibiotics/other medications) unless they are necessary for my comfort.
___I do not want hospitalization.
___Other directions/instructions that you wish to add, use the back of this form.

II. DURABLE POWER OF ATTORNEY FOR HEALTHCARE

I designate _____
Name of Agent Phone #

_____
Street Address City State Zip Code
as my attorney-in-fact (my agent). I give to my agent the power to make healthcare decisions for me in the event that I am unable, in the judgment of my attending physician, to make those healthcare decisions. If my agent is unable to serve, I designate

_____
Name of Alternate Agent Phone #

_____
Street Address City State Zip Code
My agent must act consistently with my desires as stated in this document or otherwise made known. This document gives my agent the power, consistent with laws of the State of Iowa, to consent to the withdrawal or withholding of life-sustaining procedures, as well as the power to consent to or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition. This document also gives my agent the right to examine my medical records and to consent to the disclosure of such records.

CHECK ONE BOX ONLY:
☐ 1. Declaration (Living Will) only.
☐ 2. Durable Power of Attorney for Healthcare only.
☐ 3. Both Advance Directives.

Special Instructions (see back).
☐ Yes ☐ No

Signed this _____day of _____, _____.

_____ _____
Signature Street Address

_____ _____
Print or Type name City State Zip Code

_____ _____
Social Security number Date of Birth

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC **OR** TWO WITNESSES.

NOTARY PUBLIC FORM

STATE OF IOWA, DELAWARE COUNTY, ss:

This document was acknowledged before me on _____, _____ by_____.

Commission Expiration date_____ _____
Notary Public—State of Iowa

WITNESS FORM

We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither of us is appointed as attorney in fact by this document; that neither of us is appointed as attorney in fact by this document; that neither of us are healthcare providers who are presently treating the Declarant/Principal, or employees of such healthcare providers. 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 Declarant/Principal by blood, marriage or adoption.

Witness #1 Your Signature_____ Today's Date_____

Print Name_____

Witness #2 Your Signature_____ Today's Date_____

Print Name_____

Additional Comments for Advanced Directive (Living Will):

Additional Comments for Durable Power of Attorney:

The following individuals shall not be designated as the attorney in fact to make healthcare decisions under a durable power of attorney for healthcare:

a. A healthcare provider attending the principal on the date of execution.

b. An employee of such a healthcare provider unless the individual to be designated is related to the principal by blood, marriage, or adoption.

The Power of Attorney for Healthcare Decisions or the Declaration Relating to Life-Sustaining Procedures may be revoked at any time and in any manner by which the principal/declarant is able to communicate the intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending healthcare provider upon its communication to the provider by the principal/declarant or by another to whom the principal/declarant has communicated the revocation.

Additional Instructions:

1. Let important people in your life know who you have named as proxy.
2. Make photocopies of this document and keep the original in a safe place.
3. Give copies to your proxy, all doctors involved in your care, hospital, lawyer, minister, other family members.
4. Bring a copy with you when you are admitted to the hospital.

***Adapted from the Iowa Bar Association Official Form No. 123**