Pella Regional Health Center
404 Jefferson • Pella, Iowa 50219

# POWER OF ATTORNEY FOR HEALTH CARE DECISIONS & LIVING WILL

## I. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

**This part of the document allows you to choose a person to act for you (your "Attorney In Fact" or Durable Power of Attorney for Healthcare), to make health care decisions whenever you cannot, because of unconsciousness or loss of ability to think and reason. You may choose any person to act as your Attorney In Fact who is at least 18 years old and who is not your health care provider or an employee of your health care provider on the date this document is signed. However, an employee of your health care provider on the date this is signed may act as your Attorney In Fact if such individual is related to you by blood, marriage or adoption. Your Attorney In Fact is required to make decisions according to directions you provide in writing or verbally to him or her. If your wishes are not clearly understood and defined, then your Attorney in Fact will make decisions based on what he or she believes to be in your best interest. Your Attorney In Fact is also given the right to examine your medical records. You may name more than one Attorney In Fact and you may name alternate Attorneys In Fact to act if your first choice cannot.**

**If you change your mind, you may revoke your appointment of an Attorney In Fact at any time.**

To my family, doctors, and all concerned with my care:

I hereby designate: Name(s) _____
Address _____
Telephone number (home, cell and work) _____
as my Attorney(s) In Fact and give to my Attorney(s) In Fact the power to make health care decisions for me when I am unable to make such decisions for myself.

If the person(s) designated above is unable to serve, I designate in order of preference as numbered
Name/s _____
Address _____
Telephone number (home, cell and work) _____
to serve as my Attorney(s) In Fact.

Except as otherwise specified in this document, this document gives my Attorney(s) In Fact 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 Attorney(s) In Fact the 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 my physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document. My Attorney(s) In Fact has the right to examine my medical records and to consent to the use or disclosure of such records. The following are special instructions and/or statements of my desires related to my health care: _____
_____.

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 taken according to my direction in this regard. I hereby absolve my next of kin, my Attorney In Fact, and my physician, and/or other health care provider, and/or any physician and/or health care provider 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 make health care decisions for me.

## II. DECLARATION RELATING TO LIFE-SUSTAINING TREATMENTS: ( LIVING WILL)

**This part of the document directs your physician to withhold or withdraw certain treatments (life-sustaining procedures) that could prolong the dying process. It becomes effective only at a point when, in the written opinion of your doctor (and confirmed by another doctor), you are expected to die soon and you are unable to make health decisions for yourself (because you are unconscious or unable to think and reason) or you are determined to be permanently unconscious (irreversible coma, persistent vegetative state).** ***You do not have to choose one of the specific instructions about life sustaining treatment in this section. But if you do, sign only one instruction.***

**My Living Will Declaration:**

I understand that I do not have to choose one of the instructions regarding life sustaining treatment listed below. If I choose one, I will sign below my choice. If I sign one of the choices listed below, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

**Choice 1**: I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, the chances I have for recovery, or the cost of my care, and I direct life-sustaining treatment be provided in order to prolong my life.

*If this statement reflects your desires, sign here*: _____

**Choice 2**: I want my life to be prolonged by life-sustaining treatments unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that, I do not want life-sustaining treatment to be provided or continued, I understand that this decision could or would allow me to die. The first physician's prognosis of my condition will be confirmed by a second physician.

*If this statement reflects your desires, sign here*: _____

**Choice 3**: I do not want my life to be prolonged by providing or continuing life-sustaining treatment if any of the following medical conditions exist. The first physician's prognosis of my condition will be confirmed by a second physician:

- I am in an irreversible coma or persistent vegetative state.
- I am terminally ill and life-sustaining treatment would serve only to artificially delay my death.
- Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Attorney(s) In Fact (see Part I) to consider the relief of suffering and the quality of my life as well as the extent of possibly prolonging my life.

I understand that this decision could or would allow me to die.

*If this statement reflects your desires, sign here*: _____

## - AND/OR -

Note: Write specific instructions or statements of desires regarding your health care (optional)

_____

_____

_____

## SIGNATURE PAGE

**Patient**

I, _____, the patient, sign my name to this instrument this ____ day of _____, 20__, 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.*

_____ _____
(Patient Signature) (Date of Birth)

***NOTE: This document must be signed before two witnesses or a notary public. Witnesses must complete Section A or a Notary must complete Section B, below. If you have questions about this form or need assistance to complete it, you should contact the PRHC chaplain, case management; or your own personal attorney.**

**SECTION A. Witnesses**

We, the undersigned, hereby state that we signed this document in the presence of each other and the patient and we witnessed the signing of the document by the patient or by another person acting on behalf of the patient at the direction of the patient; 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 patient, 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 patient 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 -**

**SECTION B. Notary Public**

The State of Iowa )
) ss.
The County of _____)
Signed and sworn to before me by _____, the patient, this _____ day of _____, 20___

(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 treatment” means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, and when applied to a person in a terminal condition, would serve to only prolong the dying process. “Life sustaining treatment” 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 treatment” 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 should set forth your specific instructions in the space provided on page 2*.

3. The following individuals shall not be designated as the Attorney(s) In Fact to make health care decisions under a durable power of attorney for health care:

    a. A health care provider attending the patient on the date of implementation.
    b. An employee of such a health care provider unless the individual to be designated is related to the patient by blood, marriage, or adoption within the third degree of relation.
    c. An individual who is less than 18 years of age.

4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining treatments may be revoked at any time and in any manner by which the patient is able to communicate the intent to revoke, without regard to physical condition. A revocation is only effective as to your health care provider upon communication to the provider by the patient or his or her representative.

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

6. A declaration relating to use of life-sustaining procedures (a.k.a. a Living Will) will be effective only when the patient’s condition is determined to be terminal or the patient is in a state of permanent unconsciousness, and the patient 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(s) In Fact (agent) and to alternate designated Attorneys In Fact (if any).

Made Fillable by eForms.