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Legal Forms & Services

FirstName LastName

IOWA
HEALTH CARE DIRECTIVE

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in Iowa

After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Option 2: Notary Only

1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

This document includes the following:

Power of attorney for health care designating a health care attorney in fact to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my attorney in fact should act in my best interest.

Declaration relating to the use of life-sustaining procedures with end-of-life health care instructions to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

POWER OF ATTORNEY FOR HEALTH CARE

I, FirstName LastName, being an adult of sound mind, hereby designate:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Iowa 11111

Phone: 1111111111

Email: emailaddress@email.com

as my attorney in fact (my agent) and give to my agent the power 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 or otherwise made known.

If my first choice above is not willing, able, or reasonably available, I designate the following individual as my alternative attorney in fact:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Iowa 11111

Phone: 1111111111

Email: emailaddress@email.com

AUTHORITY OF ATTORNEY IN FACT. Except as otherwise specified in this document, this document gives my attorney in fact the power, where otherwise consistent with the law of this state, 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 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 attorney in fact has the right to examine my medical records and to consent to disclosure of such records.

Limitations on Attorney in Fact's Authority:

I do not wish to limit the authority of my attorney in fact at this time.

Specific Instructions for Attorney in Fact:

I do not have specific instructions for my attorney in fact at this time.

DECLARATION RELATING TO THE USE
OF
LIFE-SUSTAINING PROCEDURES

I, FirstName LastName, being an adult of sound mind, voluntarily declare the following in the event it is determined that I lack capacity to make or communicate my health care decisions pursuant to the laws of Iowa.

If I should have an incurable or reversible 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.

ADDITIONAL INSTRUCTIONS.

I do not wish to leave additional instructions at this time.

SIGNATURES

This document must be signed and dated by me. It also must either be verified by two witnesses in my presence and the presence of each other (Option 1) OR a notary public (Option 2). It must be signed and dated when it is witnessed or verified.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: _____

Date signed: _____

If I cannot sign my name, I ask the below named person to sign for me.

Signature: _____

Printed Name:_____

TWO WITNESSES (OPTION 1)

Witness One. In my presence on _____ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not a relative of the principal by blood, marriage, or adoption within the third degree of consanguinity.
- I am not a health care provider attending the principal.
- I am not an employee of a health care provider attending the principal.
- I am at least eighteen years of age.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two. In my presence on _____ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not a relative of the principal by blood, marriage, or adoption within the third degree of consanguinity.
- I am not a health care provider attending the principal.
- I am not an employee of a health care provider attending the principal.
- I am at least eighteen years of age.

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

_____

Witness Two Phone: _____

OR

NOTARY PUBLIC (OPTION 2)

In my presence on _____ (date), FirstName LastName acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Notary Public Signature: _____

Commission Expiration Date: _____