Durable Power of Attorney for Health Care

(Iowa Code §§ 144B.1 to 144B.12)

1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint an attorney in fact in case of my incapacity.

2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.

3. **Regarding end-of-life matters:** [initial one of the two choices]

   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.

4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

5. I give no one (including my attorney in fact) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.

6. Apart from the matters covered above, I appoint the person named herein as my attorney in fact to make health-care decisions for me. I give my attorney in fact full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed attorney in fact is unavailable, unable, or

unwilling to serve, I appoint an alternate attorney in fact herein to serve with the same power and authority.

(Signature*) (Date)

(Address)

STATEMENT OF WITNESSES: By signing below, I declare that I signed this Durable Power of Attorney for Health Care in the presence of the other witness and the principal (the person who signed above), and that I witnessed the signing by the principal or other person acting on behalf of and at the principal's direction. The principal appears to be of sound mind and free from duress, fraud, or undue influence. I am 18 years of age or older. **I am not (1) the attorney in fact or alternate attorney in fact appointed in this document,** (2) a health-care provider attending the principal on the date this document is signed, or (3) an employee of a health-care provider attending the principal on the date this document is signed. Also, at least one of us is not related to the principal by blood, marriage, or adoption within the third degree of consanguinity.

(Signature of witness) (Signature of witness)

(Address) (Address)

ATTORNEY IN FACT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

ALTERNATE ATTORNEY IN FACT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

* **Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your attorneys in fact). You should sign this document in the presence of two witnesses. You may appoint any adult to be your attorney in fact except (1) a health-care provider attending you on the date you sign this document, or (2) a nonrelative employee of a health-care provider attending you on the date you sign this document. A "nonrelative" means a person not related to you by blood, marriage, or adoption within the third degree of consanguinity.

Durable Power of Attorney for Health Care
(signed document inside)

NO BLOOD