DECLARATION RELATING TO USE OF LIFE-SUSTAINING PROCEDURES

DECLARATION
(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 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.

YES__ NO__ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed on _____.

_____ _____
Signature of Declarant Type or Print Name of Declarant

_____ _____
Address, Street, City, State and Zip Date of Birth of Declarant

This Declaration must be witnessed by two persons or be notarized.

STATE OF IOWA , COUNTY OF _____

This record was acknowledged before me on _____, by _____
_____.

_____
Signature of Notary Public

_____ _____
Signature of 1st Witness Signature of 2nd Witness

_____ _____
Type or Print Name of Witness Type or Print Name of Witness

_____ _____
Street Address, City, State, Zip Street Address, City, State, Zip

By signing this form I declare that I signed this form in the presence of the other witness and the Declarant and I witnessed the signing by the Declarant or by another person acting on behalf of and at the Declarant's direction.

(IMPORTANT: PLEASE SEE NOTES AS TO USE ON REVERSE SIDE)

General Information on Declaration Relating to Use of Life-Sustaining Procedures

By Iowa Law:

1. This Declaration will be given effect only when the Declarant's condition is determined to be terminal or Declarant is in a state of permanent unconsciousness and the Declarant is not able to make treatment decisions.
2. "Life-sustaining procedure" does not include the provision of nutrition or hydration except when required to be provided parenterally or through intubation or the administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain. If you do not wish to have nutrition or hydration withdrawn under any circumstances, please consult an attorney for appropriate modification of this Declaration.
3. It is the responsibility of the Declarant to provide the Declarant's attending physician or health care provider with this Declaration.
4. This Declaration may be revoked in any manner by which the Declarant is able to communicate the Declarant's intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending physician upon communication to such physician by the Declarant, or by another to whom the revocation was communicated by the Declarant.
5. If this form is witnessed rather than notarized, at least one witness shall be an individual who is not a relative of the Declarant by blood, marriage or adoption within the third degree of consanguinity.
   The following individuals shall not witness for a Declaration:
   a. A health care provider attending the Declarant on the date of execution.
   b. An employee of a health care provider attending the Declarant on the date of execution.
   c. An individual who is less than eighteen years of age.