## GENERAL INFORMATION REGARDING LIVING WILLS

1. "Life-sustaining procedure" 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 only to prolong the dying process. "Life sustaining procedure" 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 procedure" include nutrition and hydration (food and water) only when provided parenterally 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.

3. The declaration relating to use of 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 health care provider upon its communication to the provider by the principal declarant or by another to whom the principal/declarant has communicated the revocation.

4. A declaration relating to use of life-sustaining procedures will be given effect only when the declarant's condition is determined to be terminal or the declarant is in a state of permanent unconsciousness, and the declarant is not able to make treatment decisions.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Provide a copy to anyone whom you have designated to make health care decisions for you in a Durable Health Care Power of Attorney.
2. Place original in a safe place known and accessible to family members or close friends.
3. Provide a copy to your doctor.
4. Provide a copy(s) to family member(s).

**NOTE: For additional copies of this form, go to the Iowa Legal Aid Website (iowalegalaid.org). You may go directly to a pdf file of this document by putting iowalegalaid.org/link.cfm?898 in your browser.**

**DECLARATION RELATING TO USE OF 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 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.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

Additional provisions:

Signed this _____day of _____, _____.

_____
(Declarant)

Address: _____

_____

SSN:#_____

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.

**NOTARY PUBLIC FORM**

STATE OF IOWA, COUNTY OF _____, SS:

On this_____ day of _____,_____, before me, the undersigned, a Notary Public in and for said state, personally appeared _____, to me known to be the person named in and who executed the foregoing instrument and acknowledged that he executed the same as his voluntary act and deed.

_____
Notary Public in and for the State of Iowa

**WITNESS FORM**

We, the undersigned, hereby state that:

- we signed this document in the presence of each other and the Declarant;
- we witnessed the signing of the document by the Declarant or by another person acting on behalf of the Declarant at the direction of the Declarant;
- neither of us is a health care provider who is presently treating the Declarant, or an employees of such a health care provider;
- we are both at least 18 years of age; and
- at least one of us is not related to the Declarant by blood, marriage or adoption.

| | |
|---|---|
| _____ | _____ |
| Signature of 1st Witness | Signature of 2nd Witness |
| _____ | _____ |
| (Type or Print Name of Witness) | (Type or Print Name of Witness) |
| _____ | _____ |
| Street Address | Street Address |
| _____ | _____ |
| City State Zip Code | City State Zip Code |