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DECLARATION

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 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 process of dying and are not necessary to my comfort or freedom from pain.

Signed this _____day of _____, _____
(year)

Signature _____

City, County and State of Residence_____

The declarant is known to me and voluntarily signed this document in my presence.

Witness_____

Address_____

Witness_____

Address_____

County of _____

State of Iowa

Before me, the undersigned authority, personally appeared _____, _____, and _____ known to me to be declarant and the witnesses whose names are signed to the foregoing instrument, and who, in the presence of each other, did subscribe their names to the Declaration on this date.

My commission expires:

_____
Notary Public

(Seal)