Document 2025 474

Book 2025 Page 474 Type 06 008 Pages 8
Date 2/25/2025 Time 11:30:40AM
Rec Amt $42.00

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BRANDY MACUMBER, COUNTY RECORDER
MADISON COUNTY IOWA

CHEK

Medical Power of Attorney
Title of Document (on/above line)

PREPARER INFORMATION:
(name, address, phone number)
Peggy Shutt
606 E. Washington, Winterset, Ia 50273
515 462-1598

~~**TAXPAYER INFORMATION:**~~
~~(name and mailing address)~~

RETURN DOCUMENT TO:
(name and mailing address)
Peggy Shutt
606 E. Washington, Winterset, Ia. 50273

GRANTOR:
(name)
Peggy Shutt

GRANTEE:
(name)
Frank Shutt

MEDICAL POWER OF ATTORNEY

IMPORTANT INFORMATION

IT IS CRUCIAL THAT YOU REVIEW THE FOLLOWING INFORMATION BEFORE YOU SIGN THIS DOCUMENT. READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A HEALTHCARE PROFESSIONAL OR ATTORNEY IF YOU DO NOT UNDERSTAND ANY OF THE TERMS.

By signing this document, you are giving authority to the person you are designating as your agent to make medical decisions on your behalf. Medical decisions can include any medical service, treatment, medical procedure, diagnosis or treat both mental and physical conditions. Your agent will be able to act with the same authority you would have if you were able to act for yourself and will have the authority to consent and refuse to consent to medical treatment **including decisions about withdrawing or withholding life-sustaining treatment**. It is, therefore, important that you know and trust your agent and that your agent is aware of your preferences for healthcare treatment.

Even after you sign this document, you will still be able to make your healthcare decisions assuming you are still considered mentally competent. Your agent cannot act on your behalf until your physician has determined that you are no longer physically or mentally able to make medical decisions unless otherwise stated in this document.

The person you choose as your agent must be at least 18 years old and someone that you trust with your healthcare. Your agent is not liable for any decisions they make on your behalf, as long as those decisions were made in good faith. You should make sure that you have chosen an agent who wants to take on the role of agent. Discuss your medical preferences with your agent so they are aware of your wishes. Review this document with your agent so they are aware of their role. You also may choose up to two alternate agents in case your main agent is unavailable to act. Your alternate agent(s) should also be over 18 and aware of your preferences.

You may revoke this document at any time while you are still competent to do so. You may revoke it by telling your medical provider and your agent that you are revoking the document or you may provide them a written revocation (recommended). If you execute another power of attorney later, that will have the effect of revoking this one.

PART I. APPOINTMENT OF HEALTHCARE AGENT

I, Peggy Ilene Shutt, of 606 E Washington St, Winterset, Iowa, 50273 (hereinafter known as the "Principal") hereby appoint Frank Edward Shutt of 606 East Washington Street, Winterset , Iowa, 50273 (hereinafter known as the "Agent") as my Agent to make any and all medical decisions on my behalf, except to the extent that I limit in this document. My Agent can be reached at the following contact information:

Phone number: (515) 462-1598
Email address: _____

APPOINTMENT OF ALTERNATE AGENT(S)

If my Agent appointed above is unable or unwilling to serve, I appoint the following person(s) to serve as Agent(s) in the order set forth below with the authority to make health care decisions on my behalf as provided herein:

Alternate Agent #1

Teresa Elaine Shutt of 5120 Waterfront Ct, Pleasant Hill, Iowa, 50327 can be best reached at the following phone number: (515) 250-6833.

If my main Agent, Frank Edward Shutt, and Alternate Agent #1, Teresa Elaine Shutt, are unable or unwilling to serve, I appoint the following person to serve as my 2nd Alternate Agent with the authority to make health care decisions on my behalf as provided herein:

Alternate Agent #2

Paul Frank Shutt of _____ can be best reached at the following phone number: (515) 494-3391.

LIMITATIONS OF MY AGENT

Initial

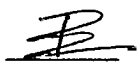
F.S. - The Agent shall not have any limitations to the medical decision making powers they may make on my behalf. Therefore I acknowledge that the Agent shall have the right to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.

_____ - I intend for my Agent to be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160-164.

DURATION

Unless stated otherwise herein, this document shall remain in effect until I revoke it. I understand that I cannot revoke this document if I am considered incompetent to make my own decisions.

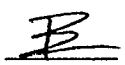
Initial

 - This document shall not have an end date and shall terminate upon revocation, a new medical power of attorney, or my death.

WHEN MY AGENT'S AUTHORITY BECOMES EFFECTIVE

My Agent's authority becomes effective:

Initial

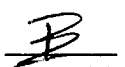
 - Immediately to make health care decisions on my behalf.

AGENT'S OBLIGATION

My Agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare, any instructions I give in Part II of this form, and my other wishes to the extent known to my Agent. To the extent my wishes are unknown, my Agent shall make healthcare decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

AGENT'S POST-DEATH AUTHORITY

Initial

 - My Agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form.

PRIOR MEDICAL POWER OF ATTORNEY

By signing this document, I hereby revoke any and all prior medical powers of attorney that I may have executed.

PART II. LIVING WILL

Initial

 - I, Peggy Ilene Shutt, declare to include this Living Will as part of my Medical Power of Attorney Form.

END-OF-LIFE DECISIONS

I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have initialed below:

Initial

_____ - I choose not to prolong life if I have an incurable and irreversible condition that will result in my death within a relatively short time, or if I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or the likely risks and burdens of treatment would outweigh the expected benefits.

RELIEF FROM PAIN

Initial

_____ - With regard to pain, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

OTHER WISHES

Initial

_____ - I have no other medical requests.

PART III. DONATION OF ORGANS

Initial

_____ - I wish to donate any and all organs, parts, or tissues.

Initial

_____ - I elect to have my donated organs be used for the following: Transplant; Therapy; Research; Education;

PART IV. PRIMARY CARE PHYSICIAN

I, Peggy Ilene Shutt, do not wish to enter my Primary Care Physician's information.

ORIGINAL AND COPIES OF THIS DOCUMENT

This original document and/or copies shall be kept at the following locations: Copies will be held by my husband Frank, my daughter Teresa, my son Paul and local doctors office,

GOVERNING LAW

This document shall be governed under the laws in the State of Iowa.

EXECUTION

Principal's Signature Peggy Ilene Shutt
Peggy Ilene Shutt

Agent's Signature Frank Edward Shutt
Frank Edward Shutt

NOTARY ACKNOWLEDGMENT

STATE OF Iowa

Madison County, ss.

The undersigned, being a Notary Public certified in _____, declares that Peggy Ilene Shutt, the person creating this medical power of attorney, has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to Peggy Ilene Shutt by blood, marriage, or adoption, or a person designated to make medical decisions on their behalf. I am not directly involved in providing healthcare to the person signing. I am not entitled to any part of their estate under a will now existing or by operation of law. In the event the person acknowledging this medical power of attorney is physically unable to sign or mark this document, I verify that they directly indicated to me that this medical power of attorney expresses their wishes and that they intend to adopt the medical power of attorney at this time.

WITNESS MY HAND AND SEAL this 25th day of February, 2025

Notary Public

BETH LOILER
Commission Number 856475
MY COMMISSION EXPIRES
6/6/2027

Print Name: Beth Loiler

My Commission Expires: 6/6/2027

WITNESS STATEMENT & ACKNOWLEDGMENT

I am not the person appointed as agent or successor agent in this medical power of attorney. I am not related to Peggy Ilene Shutt by blood or marriage. I am not entitled to any portion of their estate, nor do I have any claim against their estate. I am not the attending physician of Peggy Ilene Shutt or an employee of the attending physician. I am not involved in providing direct patient care to Peggy Ilene Shutt and not an officer, director, partner, or business office employee of the healthcare facility or of any parent organization of the healthcare facility.

WITNESS #1

Signature: Jayne Maxwell

Print Name: Jayne Maxwell Date: 2-25-25

Address: 611 W Hwy 92. Winterset, IA 50273

WITNESS #2

Signature: Molly R Meyer

Print Name: Molly R Meyer Date: 2/25/25

Address: 611 W Hwy 92 Winterset, IA 50273