53 JEFFERSON WINTERSET IOWA 50273 462-2442

DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES
(Living Will)
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
(Medical Power Of Attorney)

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

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.

II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I hereby designate Randall W. Berch (641) 728-4369
(Type or Print) Name of Agent Phone Number

2746 Hiatt Apple Road, Peru, Iowa 50222
(Type or Print) Street Address City State Zip Code

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document. My agent has the right to examine my medical records and to consent to disclosure of such records.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:

(Type or Print) Name of Alternate Phone Number

(Type or Print) Street Address City State Zip Code

OPTIONAL: ADDITIONAL PROVISIONS - Insert here specific instructions or statement of desires (if any):

COMPUTER ✓
RECORDED ✓
COMPARED

REC $ 10.00
AUD $
R.M.F. $ 1.00

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2003 JAN 24 PM 1:42
(1:42 PM)
MICKI UTSLER
RECORDER
MADISON COUNTY, IOWA

Signed this 24 day of January 2003.

Your Signature (Declarant/Principal)

122 East Benton
Street Address
Winterset, Iowa 50273
City State Zip

Nona Jill Rudolf
Type or Print Your Name
[redacted]
S.S. #

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. SEE REVERSE FOR NOTARY OR WITNESS FORMS. IF YOU WANT TO EXECUTE EITHER A LIVING WILL DECLARATION OR A MEDICAL POWER OF ATTORNEY, BUT NOT BOTH, SEPARATE FORMS ARE AVAILABLE FROM THE IOWA STATE BAR ASSOCIATION. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.

Randall W. Berch
2746 Hiatt Apple Rd.
Peru 50222

NOTARY PUBLIC FORM

STATE OF IOWA, MADISON COUNTY, ss:

This document was acknowledged before me on January ✓, 2003 by Nona Jill Rudolf.

SHARON K. SHAULL
Commission Number 149406
My Commission Expires
1-17-03

✓ Sharon K. Shaull
, Notary Public

WITNESS FORM

We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither of us is appointed as attorney in fact by this document; that neither of us are health care providers who are presently treating the Declarant/Principal, or employees of such a health care provider. We further state that we are both at least 18 years of age, and that at least one of us is not related to the Declarant/Principal by blood, marriage or adoption.

Signature of First Witness	Signature of Second 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

GENERAL INFORMATION REGARDING THIS DOCUMENT

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "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 on page 1.

3. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:

   a. A health care provider attending the principal on the date of execution.
   b. An employee of such a health care provider unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.

4. The power of attorney for health care decisions or 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.

5. It is the responsibility of the principal/declarant to provide the attending health care provider with a copy of this document.

6. 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. Place original in a safe place known and accessible to family members or close friends.
2. Provide a copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).