IOWA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Iowa Code 144B.5)

POWER OF ATTORNEY

made this _____ day of _____ (month) _____ (year)

I, _____, of The **Society of the Divine Word, Chicago Province, Headquarters in Techny, Illinois**, hereby appoint: **my Provincial or his appointee, or the Rector/Local Superior in Dubuque, Iowa**, as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains.

I am a single, adult male, and a member of the congregation of the Society of the Divine word, an Order of Roman Catholic Priests and Brothers, with its Provincial House in Techny, Illinois. It is my firm conviction that my vowed life as a member of the Congregation of the Society of the divine Word has meaning and value in any circumstance that may occur once this Illinois Statutory Short Form Power of Attorney for Health Care, which I understand to be revocable at any time, should be necessary. My decision to join the congregation of the Society of the Divine Word was a free choice and has been consistently reaffirmed over the years by my free choice to live the vowed life of a SVD.

I do not wish any third party, including my family, to look to anyone other than my appointed agent for any decision regarding my health care. That I expect my family to honor my wishes and not to interfere in decisions about my health care in no way manifests a lack of affection for my family. Rather, this expectation is consistent with my vowed life as an SVD, and thus, my decision that the proper party to make my health care decisions is the Congregation of the Society of the Divine Word through my agent. If, against my wishes, this Illinois Statutory Short Form Power of Attorney for Health Care, or any decision made because of it, is referred to a Court of Law, I expect the usual presumptions of law regarding the priority of family members to have decision-making authority about my health care to be set aside. Moreover, in no way should the legal effects of my vowed life be construed as being in conflict with any of the terms of the Illinois Statutory Short Form Power of Attorney for Health Care.

I have made a free choice in life to be an SVD, and I have made a free choice to execute this Illinois Statutory Short Form Power of Attorney for Health Care. I expect these choices to be honored, and the decisions made by my agent to be upheld.

1. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity.

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2. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 3 ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

3. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated.

Additional statement of desires, special provisions, and limitations:

_____

☐ None

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign each of the additional pages at the same time you date and sign this document.)

4. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(d) Consent to the donation of any of my organs for medical purposes.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 3 ("Statement of Desires, Special Provisions, and Limitations") above.)

5. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

6. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(You Must Date and Sign This Power of Attorney)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

_____ at _____,
(Date) (City) (State)

_____
(You sign here)

(This Power of Attorney will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature OR signed before a notary public. It is recommended that you have both the witnesses and the Notary sign the document. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this Power of Attorney.)

STATEMENT OF WITNESSES

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility, (6) your spouse, or (7) your lawful heirs or beneficiaries named in your will or a deed. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of Iowa that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this

document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, my spouse, or my lawful heirs or beneficiaries named in a Will or deed.

WITNESS 1

Signature: _____ Print name: _____

Date: _____ Residence address: _____

WITNESS 2

Signature: _____ Print name: _____

Date: _____ Residence address: _____

(At least one of the above witnesses must also sign)
I further declare under penalty of perjury under the laws of Iowa that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Signature: _____

NOTARY

State of _____ County of _____

On this _____ day of _____ 20___ before me, _____

personally appeared _____

(full name of signer of instrument) to me known (or proved to me on basis of satisfactory evidence) to be the person who is named in and who executed the foregoing instrument and acknowledged that he executed same as his own voluntary act and deed.

_____

Signature of Notary Public in State of Iowa

Print Name of Notary: _____ SEAL

My Commission Expires: _____