# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, Janet Margaret Snyder, residing at RR3 Quaker Mill Dr., Manchester, Iowa, 52057, do hereby appoint my son, Ray Snyder, RR3, Manchester, Iowa, 52057 and daughters, Kathy Gentz, 405 Quaker Mill Dr., Manchester, Iowa 52057 and Barbara Gentz, 148 Liberty, Manchester, Iowa 52057, or the survivor if one should predecease me, to serve as my agent ("Agent") to exercise the powers set forth below.

By this document I intend to create a Durable Power of Attorney For Health Care. If no agent designated in this document is available or able to serve, I request that my desires as expressed in this document be given full force and effect as a written expression of intent under applicable law.

The following powers granted to my agent shall be immediately effective and shall not be affected by my subsequent incapacity.

I desire that my wishes as expressed herein be carried out through the authority given to my agent by this document despite any contrary feelings, beliefs or opinions of members of my family, relatives, friends, conservator or guardian.

## ARTICLE I

## MY AGENT'S GENERAL POWERS REGARDING MY HEALTH CARE

My agent is authorized in my agent's sole and absolute discretion to exercise the powers granted herein relating to matters involving my health and medical care. In exercising such powers, my agent shall first try to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner, however, rudimentary. My agent is further instructed that if I am unable to give an informed consent to a proposed medical treatment, my agent shall give, withhold, withdraw or modify such consent for me based upon any treatment choices that I have expressed while competent, whether under this document or otherwise. If my agent cannot determine the treatment choice I would want made under the circumstances, then my agent should make such choice for me based upon what my agent believes to be in my best interest. Accordingly, my agent is authorized as follows:

### A

### GAIN ACCESS TO MEDICAL RECORDS AND OTHER PERSONAL INFORMATION.

To request, receive and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records, to execute any releases or other documents that may be required in order to obtain such information, and to disclose such information to such persons or entities as my agent shall deem appropriate.

### B

### EMPLOY AND DISCHARGE HEALTH CARE PERSONAL.

To employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses and therapists as my agent shall deem necessary for my physical, mental and emotional well being, and to arrange for them to be paid reasonable compensation.

### C

### GIVE, WITHHOLD, WITHDRAW OR MODIFY CONSENT TO MEDICAL TREATMENT.

To give or withhold consent to any medical procedure, test or treatment, including surgery; to arrange for my hospitalization, convalescence care, hospice or home care, to summon paramedics or other emergency medical personnel and seek emergency treatment for me, as my agent shall deem appropriate; and under circumstances in which my agent determines that certain medical procedures, tests, or treatments are no longer of any benefit to me or, where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify or

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Aff.

change consent to such procedures, tests and treatments, as well as hospitalization, convalescence care, hospice or home care which I or my agent may have previously allowed or consented to or which may have been implied due to emergency conditions. My agents decisions should be guided by taking into account (1) the provisions of this document, (2) any reliable evidence of preferences that I may have expressed on the subject, whether before or after the execution of this document, (3) what my agent believes I would want done in the circumstances if I were able to express myself, and (4) any information given to my agent by the physicians treating me as to my medical diagnosis and prognosis, and the intrusiveness, pain, risks and side effects associated with the treatment.

D

EXERCISE AND PROTECT MY RIGHTS

To exercise my right of privacy and my right to make decisions regarding my medical treatment even though the exercise of my rights might hasten the moment of my death or be against conventional medical advice.

E

AUTHORIZE RELIEF FROM PAIN

To consent to and arrange for the administration of pain relieving drugs of any kind or other surgical or medical procedures calculated to relieve my pain, including unconventional pain - relief therapies which my agent believes may be helpful, even though such drugs or procedures may have adverse side effects, may cause addiction or may hasten the moment of (but not intentionally cause) my death.

F

AUTHORIZE WITHHOLDING OF WATER AND/OR FOOD

In the event that I am being administered pain relieving drugs or other surgical or medical procedures calculated to relieve pain and my attending physician advises that my physical condition is such that recovery of a non-dependent quality of life is not possible in his medical opinion or that my illness is terminal, I hereby authorize my agent to consent to and arrange for the withholding of water and/or food even though such procedures may have adverse side effects or may hasten the moment of my death.

It is my intent that my agent shall exercise the authority to consent to or arrange for the withdrawal or non-administration of water or food in the event that further treatment is futile to the extent that it cannot and will not improve the prognosis for recovery at a time when I am incompetent, comatose or necessarily under the administration of drugs to the point where the feeding of me is involuntary or by intravenous administration.

G

GRANT RELEASES

To grant, in conjunction with any instructions given under this Article, releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by my agent or who render written opinions to my agent in connection with any matter described in this Article from all liability for damages suffered or to be suffered by me, to sign documents titled or purporting to be a "refusal to treatment", "refusal to receive water or food" and "leaving hospital against medical advice" as well as any necessary waivers or releases from liability required by a hospital, physician or surgeon to implement my wishes regarding medical treatment or non-treatment or the administration of water or food.

## ARTICLE II

### MY AGENT'S POWERS REGARDING LIFE SUSTAINING MEDICAL TREATMENT

I wish to live and enjoy life as long as possible. However, I do not wish to receive medical or other treatment which will only postpone the moment of my death from an incurable and terminal condition or prolong an irreversible coma.

For purposes of this document:

(1) Terminal conditions shall refer to a condition that is reasonably expected to result in my death within twelve (12) months regardless of the treatment that I may receive;

(2) "Irreversible coma" shall refer to a permanent loss of consciousness from which there is no reasonable possibility that I will return to a cognitive and sapien life, and shall include but not be limited to a persistent vegetative state.

Therefore, if two (2) physicians (neither of whom is related to me and each of whom is licensed to practice medicine in the state of my residence and is familiar with my condition), have diagnosed and noted in my medical records that):

(1) I am unable to give informed consent to medical treatment that is proposed or available for my condition and my condition is terminal as defined above, or

(2) I have been in a coma for at least sixty (60) days and that the coma is "irreversible" as defined above, then my agent is authorized to:

1. Direct that treatment or procedures which will only postpone the moment of my death or prolong a irreversible coma be withheld, or, if previously instituted direct that they be withdrawn;

2. Direct that procedures other than manual feeding used to provide me with nourishment and hydration, including for example all forms of intravenous and parenteral feeding, all forms of tube feeding and misting be withheld, or if previously instituted to direct that they be withdrawn;

3. Sign on my behalf any documents necessary to carry out the powers granted in this Article (including waivers or releases of liability required by any health care provider);

4. Direct and consent to the writing of a "No Code" or "Do Not Resuscitate" order by any health care provider; and

5. Order whatever is appropriate to keep me as comfortable and as free of pain as is reasonably possible, including the administration of pain-relieving drugs, surgical or medical procedures calculated to relieve my pain, and unconventional pain-relief therapies which my agent believes may be helpful even though such drugs or procedures may have adverse side effects, may cause addiction, or may hasten the moment of (but not intentionally cause) my death.

Notwithstanding the powers given my agent under this Article, my agent shall follow any other subsequent instructions, oral or written, that I may give

my agent while I am competent. However, any oral instructions or words believed to constitute oral instructions shall not be presumed or inferred from any general conversation. On the contrary they must be direct and specific.

## CERTIFICATION

I certify that I have read the foregoing provisions of this Article directing my agent to refuse medical treatment and comfort treatment for me under the circumstances specified in this Article. That such provisions have been explained to me and are understood by me to my complete satisfaction, that understand such provisions, and that such provisions state my wishes and desires under the circumstances described.

Dated this 14 day of March, 1994. Janet Margaret Snyder
Janet Margaret Snyder

## ARTICLE III

## OTHER POWERS

### A

To make all necessary arrangements for me at any hospital, Hospice, nursing home, convalescent home or similar establishment and to assure that all my essential needs are provided for at such a facility after first taking whatever steps are advisable to enable me to remain in my personal residence as long as is reasonable under the circumstances. I realize that my health may deteriorate so it becomes necessary to have around the clock nursing care if I am to remain in my personal residence. Rather than to be required to obtain around the clock nursing care and equipment which might be necessary it is then that I desire that other necessary arrangements be made for me outside the home.

### B

### MAKE ADVANCE FUNERAL ARRANGEMENTS

To make advance arrangements for my cremation, funeral and the internment of my ashes, including the purchase of a burial plot and marker if I have not done so previously. It is my intent that the expense of such advance funeral arrangements and burial shall be paid from the assets from my estate or from such other arrangements, if any, I have made prior to my demise.

### C

### MAKE ANATOMICAL GIFTS

To make anatomical gifts which will take effect at my death to such persons and organizations as my health care agent shall deem appropriate and to execute such papers and do such acts as shall be necessary, appropriate, incidental or convenient in connection with such gifts.

## ARTICLE IV

## MISCELLANEOUS PROVISIONS

The following additional provisions shall apply to this document:

A

**REIMBURSEMENT OF COSTS**

My agent shall be entitled to reimbursement for all reasonable costs and expenses actually incurred and paid for by my agent on my behalf under any provision of this document but my agent shall not be entitled to compensation for services rendered hereunder.

B

EXECUTE DOCUMENTS AND INCUR COSTS IN IMPLEMENTING THE ABOVE POWERS. My agent shall be entitled to sign, execute, deliver and acknowledge any contract or other document that may be necessary, desirable, convenient or proper in order to exercise any of the powers described in this document and to incur reasonable costs in the exercise of any such powers. In addition, my agent shall render bills for all costs incurred in the exercise of the powers granted in this document to any agent then serving under my Durable Power Of Attorney for management of property or to the trustee of any revocable or irrevocable living trust created by me prior to my demise or to the executor of my estate.

C

**GOVERNING LAW**

The laws of the State of Iowa shall govern this document in all respects including the validity, construction, interpretation and termination and shall be used to determine the validity of acts taken under authority granted in this document. I intend for this Durable Power Of Attorney For Health Care to be honored in any jurisdiction where it may be presented and for any jurisdiction to refer to Iowa law to interpret and determine the validity of this document any of the powers granted under this document if covered by Iowa Law. I direct that this instrument shall be literally construed to carry out my expressly stated desires. I believe that I, as an individual, and not the State or any government have the unrestricted right to determine these matters so long as they do not directly injure another.

D

**REVOCATION AND AMENDMENT**

I revoke all prior Durable Power Of Attorneys For Health Care (not Durable Powers of Attorney For Management Of Property) that I may have executed and I retain the right to revoke or amend this document and to substitute other agents in your place. Amendments to this document shall be made in writing by me personally (not by you) and they shall be attached to the original of this document.

E

**RESIGNATION OF AGENT**

My agent and any successive alternate agent may resign by the execution of a written resignation delivered to me, or if I am mentally incapacitated by delivery to the agent under my Durable Power Of Attorney For Management Of Property, the Trustee of any Revocable or Irrevocable Living Trust, my personal representative, and absent such person, then to any person with whom I am residing or has the care and custody of me, or in the case of resignation of an alternate agent by delivery to my agent.

If my spouse has been appointed my agent or is an alternate agent hereunder and subsequent to the execution of this document an action is filed to dissolve our marriage, then my spouse shall be deemed to have resigned as agent or alternate agent, such resignation to be effective upon the filing of such action.

In addition, the incapacity of my agent or any alternate agent shall be deemed a resignation by such individual agent or alternate agent as the case may be. For the purposes of this paragraph, a persons incapacity shall be deemed to exist when:

(a) The persons incapacity has been declared by a Court of competent jurisdiction, or

(b) When a conservator for such person has been appointed, or

(c) Upon the execution of a certificate by two (2) physicians (neither of whom is related to such person and each of whom is licensed to practice medicine in the state of such persons residence) which states the physician's opinion that the person is physically or mentally incapable of managing his or her personal or financial affairs.

The effective date of such incapacity shall be the date of the decree adjudicating the incapacity, the date of the decree appointing the conservator, or the date of the physician's certificate as the case may be.

DATED this 14 day of March, 1994, at Manchester, Delaware County, Iowa.

Janet Margaret Snyder
Janet Margaret Snyder

STATE OF IOWA )
) ss.
County of Delaware )

On this 14 day of march, 1994, before me, the undersigned, a ~~Notary Public~~ in and for the State of Iowa, personally appeared JANET MARGARET SNYDER, to me known to be the identical person named in and who executed the foregoing instrument and acknowledged that she excuted the same as her voluntary act and deed.

R.W. NIEMAN, Clerk District Court

~~Notary Public~~ in and for said County and State