Arkansas Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will Declaration
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will Declaration

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, **OR** if I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act **(initial your choices):**

[ ] to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

[ ] It is my specific directive that nutrition may be withheld after consultation with my attending physician. OR

[ ] It is my specific directive that nutrition may not be withheld.

[ ] It is my specific directive that hydration may be withheld after consultation with my attending physician. OR

[ ] It is my specific directive that hydration may not be withheld.

Other directions **(add any additional directions)**

I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act **(initial if chosen)**:

[ ] to follow the instructions of _____ (name), whom I appoint below as my Health Care Attorney-in-Fact to decide whether life-sustaining treatment should be withheld or withdrawn.

Pursuant to state law: A physician or other health care provider who is furnished a copy of the declaration shall make it a part of the declarant's medical record and, if unwilling to comply with the declaration, promptly so advise the declarant. In the case of a qualified patient, the patient's health care attorney-in-fact, in consultation with the attending physician, shall have the authority to make treatment decisions for the patient including the withholding or withdrawal of life-sustaining procedures.

Selection of Health Care Agent (Durable Power of Attorney for Health Care)

I hereby appoint _____ (name), of _____ (address), as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This Durable Power of Attorney for Health Care shall take effect in the event I become unable to make my own health care decisions. My health care agent and any alternate health care agent shall have the authority to make all health care decisions regarding any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental health or personal care. My health care agent and any alternate agent shall also have the authority to make decisions regarding the providing, withholding, or withdrawing of life-sustaining treatment pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

Optional Instructions **(insert any additional instructions):**

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below**:

[ ] any organs or parts **OR**
[ ] eyes [ ] bone and connective tissue [ ] skin
[ ] heart [ ] kidney(s) [ ] liver
[ ] lung(s) [ ] pancreas [ ] other _____
for the purposes of:
[ ] any purpose authorized by law **OR**
[ ] transplantation [ ] research [ ] therapy
[ ] medical education [ ] other limitations _____

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will Declaration
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____
On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care.

Signature _____ Date _____