ARKANSAS 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, to withhold or withdraw treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.
Other directions:

I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to follow the instructions of

_____
(name of proxy)
whom I appoint as my Health Care Proxy to make medical treatment decisions on my behalf, including whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____,20___

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness_____

Address _____

Witness _____

Address_____

ARKANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____ hereby appoint:
(name)

_____
(name, home address and telephone number of agent)

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, witholding or withdrawing of life sustaining treatment pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

Optional Instructions: If the health care agent I appoint is unable, unwilling or unavailable to act as my health care agent, then I appoint:

_____
(name, home address and telephone number)

Signed this _____ day of _____, 20___
Signature_____
Address_____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the durable power of attorney for health care willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness_____
(Sign and Print name)
Address _____

Witness _____
(Sign and Print name)
Address_____