ARKANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE (Arkansas Statute Sec 20-13-104)

I,, County of constitute and appoint address is	, of, City of
, County of	, Arkansas, hereby make,
constitute and appoint	, whose
address is	to act as my agent or attorney
in fact, to make health care and related	l personal decisions for me as
authorized in this document. Should	for any
reason be unable or unwilling to act, tem	
appoint, of	as such agent/attorney in fact,
appoint, of with the same authority.	
This Durable Power Of Attorney	-
Arkansas Durable Power of Attorney fo	•
Ann. § 20-13-104) , and I do her	
as my agen	
decisions regarding my health care durin	~ -
provider has determined that I lack of	
Specifically, and not to limit any other ri	
my attorney-in-fact shall have the power	_
records for treatment or payment decisio	
to others for purposes of treatment, payn	•
to employ and discharge physicians; to co	
medical procedures, including the with sustaining treatment, and nutrition and	
wishes expressed in my Living Will, or, i	
the then existing circumstances of my	
consideration of my best interests as d	<u>-</u>
consultation with my agent; to admir	
psychiatric hospitals, nursing homes, or	_
appropriate forms, consents and releases	
matters If I should either (1) have an ind	
that will cause my death within a relativel	
able to make decisions regarding my med	-
become permanently unconscious, my	
alternate health care agent shall also	
decisions regarding the providing, withl	
sustaining treatment pursuant to the Arl	kansas Rights of the Terminally
Ill or Permanently Unconscious Act	_

If	resigns, or is not able or ava	ilable
to make he	ealth care decisions for me, or if an agent named by a	me is
	rom me or is my spouse and legally separated from	
appoint	as successor, with all of the a	rights
	es and authority herein stated. The term "health care"	
-	meaning set forth in Ark. Code Ann. § 20-13-104(c).	
	ower of Attorney for Health Care shall not be affected b	
	t disability or incapacity.	5 5
Optional I	nstructions:	
If the	e health care agent I appoint is unable, unwilling or	
	e to act as my health care agent, then I appoint:	
	3 7 11	
/NT		4)
(Ivaiii	ne, home address and telephone number of alternate agen	L)
	as my	
alternate h	nealth care agent.	
Signed this	s day of	
0-8-100 0-110	s day of, (Day) (Month) (Year)	
Signature _		
Address		
Statement	by Witnesses (must be 19 on older).	
Statement	by Witnesses (must be 18 or older):	
I dec	clare that the person who signed this document appear	ed to
execute the	e durable power of attorney for health care willingly and	d free
from dures	ss. He or she signed (or asked another to sign for him or	r her)
this docum	nent in my presence.	·
1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
1) Witness		
	(Sign and Print name)	
Address		
	-	
2) Witness		
	(Sign and Print name)	
Address		
	<u></u>	

