Hospital: *Place patient sticker here*

WashingtonRegional Medical Center
Fayetteville, Arkansas

Advance Directive or Living Will Declaration

By _____
NAME OF PERSON SIGNING DOCUMENT

If I am permanently unconscious or 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, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, 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my specific directive that all of the life-sustaining procedures **I have checked and initialed below** be withheld or withdrawn..

- ☐ Artificially-Administered Feeding ____
- ☐ Antibiotics ____
- ☐ Cardiopulmonary Resuscitation (CPR) ____
- ☐ Respiratory Support (Mechanical Respirator) ____
- ☐ Surgery ____
- ☐ Artificially-Administered Fluids ____

Signed this _____ day of _____, _____

_____
SIGNATURE OF PERSON

TWO WITNESSES ARE REQUIRED
The declarant voluntarily signed this writing in my presence.

_____
SIGNATURE OF 1ST WITNESS

_____
ADDRESS

Instructions for using this document:

*This document includes an Advance Directive (Living Will) and Optional Durable Power of Attorney for Healthcare. Sign in front of **two** witnesses (age 18 or over, and not your relatives or proxy). If you want the Advance Directive and Durable Power of Attorney for Healthcare, you must sign this document in **two** places. This document does not have to be notarized. ORIGINAL and COPIES to patient. COPY to chart.*

OPTIONAL: *Durable Power of Attorney for Healthcare*

Anytime I am temporarily or permanently unable to make the healthcare decisions, my healthcare proxy shall be:

Name of Proxy _____

Address _____

Phone _____

I direct my attending physician to consult with my healthcare proxy in decisions regarding my care. My healthcare proxy may make all decisions about:

- My personal care
- My medical care
- Hospitalization
- Whether I shall receive medical treatment or procedure including artificial feeding or fluids, even though I may die
- Visitors, if problems arise concerning visits by friends and family

Such decisions shall be consistent with my wishes, or, if any wishes are unknown, shall be consistent with my best interest.

This document is intended to be a durable power of attorney for healthcare under A.C.A. §20-13-104 and a declaration of proxy statement under the Rights of the Terminally Ill or Permanently Unconscious Act, A.C.A. Section 20-17-201 et. seg.

Signed this _____ day of _____, _____

_____
SIGNATURE OF PERSON

_____
SIGNATURE OF 2nd WITNESS

_____
ADDRESS