ARKANSAS DECLARATION
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

_____

Name of Declarant

This document is intended to be a Durable Power of Attorney for Health Care under Ark. Code Ann. §20-13-104 and a declaration and proxy statement under the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

Declaration:

This Durable Power of Attorney shall take effect in the event of my disability or incapacity, such that I become unable to make my own health care decisions. My durable power of attorney ("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.

If I should become permanently unconscious or terminally ill and am no longer able to make decisions regarding my medical treatment, my durable power of attorney (agent) shall also have the authority to make decisions regarding the withholding or withdrawing of life-sustaining treatment as my Proxy pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

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

_____

(*Name, home address and telephone number)*

_____

as my alternate health care agent/proxy to make any and all health care decisions for me, including the withholding or withdrawal of life sustaining treatments.

I, _____, hereby appoint the below named individual as my health care agent and proxy to make any and all health care decisions for me, including the withdrawal or withholding of life sustaining treatments:

Healthcare Agent/Proxy: _____

Address: _____

_____

Phone: _____

Relation, if any: _____

In exercising this authority, my Health Care Agent/Proxy shall make health care decisions that are consistent with my desires as stated in my Living Will or if my wishes are not known, shall be consistent with my best interest.

Signed this _____ day of _____, 20___ at _____ a.m./p.m.

_____

Signature of Declarant

Witnesses:

The declarant voluntarily signed this writing in my presence; appeared to be 18 years of age or older, sound mind and acting without undue influence, fraud or restraint.

_____ _____

Signature of Witness *Signature of Witness*

_____ _____

Address *Address*

_____ _____

City and State *City and State*

Date/Time: _____/_____ *Date/Time:* _____/_____