DECLARATION OF LIVING WILL OF

_____

[*Name of Declarant*]

If I should have an incurable or irreversible condition with no hope of recovery 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 Common Law and 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.

Additionally, 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 life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain.

Section 1: Life-Sustaining Treatments

The life-sustaining treatments which **may be withheld or withdrawn** are (check all that apply):

1

- ☐ Cardiopulmonary Resuscitation.
- ☐ Mechanical Breathing.
- ☐ Major Surgery.
- ☐ Kidney Dialysis.
- ☐ Chemotherapy.
- ☐ Minor Surgery (unless necessary for my comfort or to alleviate pain).
- ☐ Invasive Diagnostic Tests.
- ☐ Antibiotics.
- ☐ Blood Products.
- ☐ Other Medications not Necessary for Alleviation of Pain.

Add other medical directives, if any: _____**.**

Section 2: Artificial Nutrition and Hydration

I understand that Arkansas law requires me to make my wishes regarding artificial nutrition and hydration known separately from the above directions. Therefore, by initialing the appropriate line(s) below, I specifically:

_____ DIRECT that **artificial nutrition may be withheld** or withdrawn after consultation with my attending physician.

_____ DIRECT that **artificial hydration may be withheld** or withdrawn after consultation with my attending physician.

SIGNED this _____ day of _____ 20_____.

_____
Signature

We, the undersigned, do hereby certify that the Declarant, _____ subscribed this Declaration of Living Will in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

_____
Witness

_____
Address

_____
City, State and Zip Code

_____
Witness

_____
Address

_____
City, State and Zip Code

DURABLE POWER OF ATTORNEY FOR HEALTH CARE OF

_____

[*Name of Declarant*]

Pursuant to the Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann. § 20-13-104) (the "Act"), I hereby designate and appoint _____ as my agent, or attorney in fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment or payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters.

If _____ resigns, or is not able or available to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term "health care" shall have the meaning set forth in Ark. Code Ann. § 20-13-104(c). This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

SIGNED this _____ day of _____ 20_____.

_____

Signature

We, the undersigned, do hereby certify that the Declarant, _____ subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

_____

Witness

_____

Address

_____

City, State and Zip Code

_____

Witness

_____

Address

_____

City, State and Zip Code