Advanced Directive and Durable Power of Attorney

Living Will Declaration and Durable Power of Attorney for Health Care

State of Arkansas

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advanced Directive or Durable Power of Attorney.

Recap. What Is?
Advanced Directive

An Advanced Directive is a legal document that specifically spells out how you want to be cared for as the end draws near.

This is a legal document and needs to be in accord with your local State laws.

This must be completed and notarized and/or signed by witnesses. Until electronic signatures are more common, the signed form must be in a defined location which is known to the Health care proxy, the attorney, the doctor.

Recap. What Is?
Durable Power of Attorney

An Advanced Directive is not enough. It must be known to your caregivers.

You will need someone to see that your Advanced Directive is adhered to if you are not in a position to do so.

This person is designated by a document called a durable power of attorney for health matters.

You must choose your proxy/surrogate wisely.

The document designating the proxy/surrogate must be notarized and signed

Until electronic signatures are more common, the signed form must be in a defined location which is known to the Health care proxy, the attorney, the doctor.

LIVING WILL DECLARATION

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 which are no longer necessary for my comfort or to alleviate pain.

The life-sustaining treatments which may be **withheld or withdrawn** are:

- ☐ Antibiotics
- ☐ Chemotherapy
- ☐ Blood Products
- ☐ Respiratory Support
- ☐ Kidney Dialysis
- ☐ Invasive Diagnostic Tests
- ☐ Mechanical Breathing
- ☐ Cardiopulmonary Resuscitation
- ☐ Major Surgery
- ☐ Artificially Administered Feeding and Fluids
- ☐ Minor Surgery (unless necessary for my comfort or to alleviate pain)

Declarant's Full Name: _____

Age: _____ **Birth Date:** _____ **SSN:** _____

Address: _____

City/State/Zip: _____

OPTIONAL ORGAN AND TISSUE DONATION

I wish to donate for transplantation and/or medical research the following anatomical gift:

- ☐ Body
- ☐ Liver
- ☐ Bone
- ☐ Lungs
- ☐ Pancreas
- ☐ Eyes
- ☐ Skin
- ☐ Heart
- ☐ Kidneys
- ☐ Heart Valves
- ☐ All listed
- ☐ Blood and Tissue Samples for Lab Tests
- ☐ Other_____
- ☐ I do not wish to donate any organs, blood or tissue

Other/Additional Instructions: _____

_____

ARTIFICIAL NUTRITION AND HYDRATION - I understand Arkansas law requires me to make my wishes regarding artificial nutrition and hydration known separately from other declarations. 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.

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.

Declarant's Signature: _____ **Date:** _____

The declarant voluntarily signed this writing in my presence:

Witness _____ **Witness** _____

YOU MAY REVOKE THIS DECLARATION AT ANY TIME IN ANY MANNER.

Address _____ **Address** _____

IMPORTANT: Please DO NOT file this document in a safety deposit box or other place where it cannot be accessed. KEEP THE ORIGINAL WITH YOU AT HOME AND MAKE ITS LOCATION KNOWN TO SOMEONE CLOSE TO YOU.

Please ask your nurse or physician if you have questions or need assistance completing this form.

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	Witness
_____	_____
Address	Address
_____	_____
City, State and Zip Code	City, State and Zip Code