Advance Directive Form

NOTE: This form is being provided to you as a public service. The attached forms are provided “as is” and are not the substitute for the advice of an attorney. By providing these forms and information, Everplans is not providing legal advice to you. Consult an attorney if you need legal advice of any nature.

Read more and get more forms at Everplans’ Advance Directive page.
Living Will
And
Durable Power of Attorney for Health Care

Provided as a public service by
the Health Law Section of the Arkansas Bar Association

Please read the Advance Directive Information available on the Arkansas Bar Association’s website at http://www.arkbar.com/ carefully before completing these forms.

NOTE: The form Living Will and Durable Power of Attorney for Health Care are being provided to you as a public service. The attached forms are provided “as is” and are not the substitute for the advice of an attorney. By providing these forms and the Advance Directive Information, neither the Arkansas Bar Association nor its Health Law Section is providing legal advice to you. Consult an attorney if you need legal advice of any nature.
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The life-sustaining treatments which may be withheld or withdrawn are (check all that apply):

- [ ] 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:____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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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  Witness

______________________________  ________________________________
Address  Address

______________________________  ________________________________
City, State and Zip Code  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