



compassion & choices

Care & Choices at the End of Life.

Advance Directive

Planning for Important
Healthcare Decisions

Arkansas



Arkansas Declaration

If I 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 or 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 treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.

Other directions:

I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to follow the instructions of

(name of proxy)

whom I appoint as my Healthcare Proxy to make medical treatment decisions on my behalf, including whether life-sustaining treatment should be withheld or withdrawn.

(Continued)



Signed this _____ day of _____, _____.
(day) (month) (year)

Signature: _____

Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____

Address: _____

Witness: _____

Address: _____



Arkansas Durable Power of Attorney for Healthcare

I, _____, hereby appoint:
(name)

(name of agent)

(home address and telephone number of agent)

as my healthcare agent to make any and all healthcare decisions for me, except to the extent that I state otherwise.

This Durable Power of Attorney for Healthcare shall take effect in the event I become unable to make my own healthcare decisions. My healthcare agent and any alternate healthcare agent shall have the authority to make all healthcare decisions regarding any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental health or personal care. My healthcare agent and any alternate agent shall also have the authority to make decisions regarding the providing, withholding or withdrawing of life sustaining treatment pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

Optional Instructions:

If the healthcare agent I appoint is unable, unwilling or unavailable to act as my healthcare agent, then I appoint:

(name of agent)

(home address and telephone number of agent)

(Continued)



Signed this _____ day of _____, _____.
(day) (month) (year)

Signature _____

Address _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the durable power of attorney for healthcare willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness _____
(Sign and Print name)

Address _____

Witness _____
(Sign and Print name)

Address _____