

The revocation is effective when it is communicated to your physician.

**DURABLE POWER OF ATTORNEY
FOR HEALTH CARE PURPOSES**

**STATE OF ARKANSAS)
COUNTY OF PULASKI)**

KNOW ALL MEN BY THESE PRESENTS:

1. This Durable Power of Attorney for Health Care is prepared and executed in accordance with the "Durable Power of Attorney for Health Care Act" Arkansas Code Annotated 20-13-104.
2. This document recognizes the right of an individual to control all aspects of his or her personal care and medical treatment. It also recognizes that if the individual becomes incapacitated, his or her right to control treatment may be denied unless the individual, as principal, can delegate the decision-making power to a trusted agent and be sure that the agent's power to make personal and health care decisions for the principal will be effective to the same extent as though made by the principal.
3. For the purposes of this document, the term "health care" means any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for the patient's physical or mental health or personal care. The term "health care" shall not include decisions concerning life-sustaining treatment as set forth in Arkansas Code Annotated 20-17-201 et seq. However, since Arkansas Law provides that a durable power of attorney for health care may contain the declaration set forth in 20-17-202 relating to such life-sustaining treatments, the declarations will be included in this document.
4. I, _____ of _____, _____ County, Arkansas, state that I am above the age of 18 years and that I am of sound mind on the date this Power of Attorney is executed. I hereby revoke any and all Powers of Attorney that I may previously have executed.
5. I appoint _____ of _____, _____ County, _____ as my trusted agent and lawful attorney, for me and in my name, place and stead and for me to do and perform any and every act whatsoever as fully as I might if personally present, including but not specifically limited to the following:
 - A. If the time comes when I can no longer take part in decisions for my own future, this Power of Attorney shall stand as an expression of my wishes and as my declaration while I am of sound mind;
 - B. 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 or comatose, then I direct my trusted agent and lawful attorney to direct my physician(s) or other care giver(s) to withhold or withdraw treatment that only prolongs the process of dying, or that is only for my comfort or to alleviate pain;
 - C. The life sustaining treatments which may be withheld or withdrawn include, but are not limited to: antibiotics, nutrition, hydration, cardiac resuscitation, respiratory support and surgery. To be specific, (check and initial as many as apply)

Check One

Initial

Yes ___ No ___ It is my specific directive that nutrition be withheld. _____

Yes ___ No ___ It is my specific directive that hydration be withheld. _____

Yes ___ No ___ It is my specific directive that if my heart should stop or become incapable of functioning on its own, that it shall not be re-started, resuscitated or supported. _____

Yes ___ No ___ It is my specific directive that if I am unable to breathe on my own that a respirator shall not be used. _____

Yes ___ No ___ It is my specific directive that antibiotics shall not be used. _____

6. If there is any need to interpret or supplement this Power of Attorney regarding whether life sustaining treatments should be withheld or withdrawn, my trusted agent and attorney in fact shall decide whether life sustaining treatment should be continued, withheld or withdrawn.
7. This Power of Attorney shall not be affected by my subsequent disability or incapacity.
8. All acts done by my trusted agent and Attorney in fact pursuant to this Power of Attorney during any period during which I am disabled or incapacitated shall have the same effect and inure to the benefit of and bind me and my successors in interest as if I were competent and not disabled.
9. If, following execution of this Power of Attorney, a court of competent jurisdiction appoints a conservator or guardian of me or of my estate, or other fiduciary charged with my care and the management of all of my property or all of my property except specified exclusions, my trusted agent and Attorney in fact appointed herein is accountable to such fiduciary as well as to me.
10. Any fiduciary so appointed shall have the same power to revoke or amend this Power of Attorney that I would have if I were not disabled or incapacitated.

IN WITNESS WHEREOF, I have hereunto set my hand this ____ day of _____, 2____:

(Signature)

(Printed Name)

Yes ___ No ___ It is my specific directive that if I am unable to breathe on my own that a respirator shall not be used. _____

Yes ___ No ___ It is my specific directive that antibiotics shall not be used. _____

5. If there is any need to supplement this Declaration as to whether life sustaining treatments should be withheld or withdrawn, I direct my attending physician, pursuant to the Act, to follow the instructions of _____ of _____, _____ County, _____, whom I appoint as my Health Care Proxy to decide whether life sustaining treatment should be withheld or withdrawn. If _____ is unable or unwilling to serve in such capacity, I hereby appoint _____ to serve as such Health Care Proxy.

IN TESTIMONY WHEREOF, I voluntarily sign my name to this Declaration in the presence of the undersigned whom I have requested to attest the same as witnesses at _____, on the _____ day of _____, 2_____.

(Signature)

Printed Name: _____
ATTESTATION

We, the undersigned bear witness that the declarant signed the foregoing Living Will and Declaration in the presence of each of us and at the time of signing the document declared the instrument to be his/her declaration and requested us to sign our names as witnesses and that we, and each of us, in the presence of the declarant, and in the presence of each other, thereupon signed our names as witnesses.

Dated this _____ day of _____, 2_____:

Witness _____

Address _____

Printed Name _____

Witness _____

Address _____

Printed Name _____

Witness _____

Address _____

Printed Name _____