APPOINTMENT OF HEALTH CARE AGENT
ARKANSAS

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent	**Alternate**
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip	_____ City State Zip
(____) _____ Area Code Home Phone Number	(____) _____ Area Code Home Phone Number
(____) _____ Area Code Work Phone Number	(____) _____ Area Code Work Phone Number
(____) _____ Area Code Cell Phone Number	(____) _____ Area Code Cell Phone Number
_____ Patient's name (please print or type) Date	_____ Signature of patient (must be 18+ or emancipated minor)

To be legally valid, **either** block A or block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.
2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage or adoption and I would not be entitled to any portion of the patient's estate upon his/her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____ Signature of Witness #1 _____ Signature of Witness #2

Block B

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed the above or acknowledged the signature above as his/her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud or undue influence.

My Commission Expires: _____
Signature of Notary Public

ACCEPTANCE OF SURROGATE SELECTION

I accept the appointment as surrogate for _____ (patient) and understand that I have the authority to make all medical decisions.

_____ Signature of Surrogate _____ Date / Time

Formatted May 2015

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and <u>either</u> witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have either of the following conditions (you may check either/both/neither of these items if you want):

☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ **End Stage Illnesses**: I have an illness that has reached its final stages in spite of full treatment. Examples: widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT WANT the treatment.

☐ YES ☐ NO	**CPR (Cardiopulmonary Resuscitation)**: To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions and breathing assistance.
☐ YES ☐ NO	**Life Support / Other Artificial Support**: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ YES ☐ NO	**Treatment of New Conditions**: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ YES ☐ NO	**Tube feeding / IV fluids**: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.: _____
_____
_____
(Attach additional pages if necessary.)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue
☐ My entire body
☐ Only the following organs/tissues: _____
_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, another witness should not be the person you appoint as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature _____ Date: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.
2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage or adoption and I would not be entitled to any portion of the patient's estate upon his/her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____ _____
Signature of Witness #1 Signature of Witness #2

This document may be notarized instead of witnessed:

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed the above or acknowledged the signature above as his/her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud or undue influence.

My Commission Expires: _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent