

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The life-sustaining treatments which **may be withheld or withdrawn** are (check all that apply):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 _____

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_____ DIRECT that **artificial nutrition may be withheld** or withdrawn after consultation with my attending physician.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