ARKANSAS LIVING WILL DECLARATION

This Declaration is made pursuant to the provisions of the ARKANSAS RIGHTS OF THE TERMINALLY ILL OR PERMANENTLY UNCONSCIOUS ACT as follows:

If the time comes when I can no longer take part in making decisions for my own future, let this statement stand as an expression of my wishes and my declaration while I am of sound mind.

I, _____ (the "Declarant"), being of sound mind, having reached the age of eighteen (18) years, residing in the State of Arkansas, do hereby make, publish and declare the following:

1. 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, I direct my attending physician, pursuant to 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.

2. If I should become permanently unconscious, I direct my attending physician, pursuant to the same Act, to withhold or withdraw life-sustaining treatments which are no longer necessary to my comfort or to alleviate pain.

These life-sustaining treatments which may be withheld or withdrawn include, but are not limited to:

Antibiotics

Artificially Administered Feeding & Fluids

Cardiac Resuscitation

Respiratory Support

Surgery

3. In the absence of my ability to give directions regarding the use of such procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequence from such refusal. Therefore, if I should become permanently unconscious, I direct my attending physician to follow the instructions of _____, whom I appoint as my HEALTH CARE PROXY to decide whether life-sustaining treatments should be withheld or withdrawn.

4. It is my intention for my physician or health care provider to be furnished a copy of this declaration and for it to become a part of my medical records and, if they are unwilling to comply with this declaration, to promptly so advise me and my Health Care Proxy.

5. It is my intention to relieve all persons from any and all civil and criminal liability for good faith reliance on this Declaration in carrying out these instructions, and this Declaration should be construed by my family and attending physicians in the spirit that I do not desire aggressive medical treatment or life-sustaining procedures in any of the circumstances described herein.

6. I understand the full import of this directive, and I am emotionally and mentally competent to make this Declaration.

7. Additional Instructions: _____

_____

_____

_____

_____

8. I have discussed my desires concerning terminal care with _____ and _____, in addition to my health care proxy and trust them to make decisions for such care in my behalf in the event my health care proxy is unable to do so.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _____ day of _____, 20_____.

_____

Signature of Person Making Declaration (Declarant)

_____

(Type or Print Name of Declarant)

_____

Street Address

_____

City State Zip Code

NOTICE REGARDING WITNESSES

You must have two adult witnesses who will not receive your assets when you die (whether you die with or without a will), and who are not your spouse, child, grandchild, brother or sister, or an employee at the health care facility where you are a patient.

ATTESTATION

Subscribed by _____, in the presence of each of us, the undersigned, and at the same time declared by him to us to be his Living Will, and we, thereupon, at the request of the Declarant in his presence and in the presence of each other, sign our names hereto as witnesses this _____ day of _____, 20_____.

_____ _____

Signature of 1st Witness Signature of 1st Witness

_____ _____

(Type or Print Name of Witness) (Type or Print Name of Witness)

_____ _____

Street Address Street Address

_____ _____

City State Zip Code City State Zip Code

Subscribed and acknowledged before me by the said _____, Declarant, and subscribed and sworn to before me by the said _____, _____, witnesses, on this _____ day of _____, 20_____.

_____

Notary Public

My Commission Expires: _____