DURABLE POWER OF ATTORNEY FOR HEALTH CARE OF

_____

Pursuant to the Arkansas Healthcare Decisions Act (Ark. Code Ann. § 20-6-101 et seq.) (the "Act"), I hereby designate and appoint _____ as my agent, or attorney-in-fact, whose phone number is _____, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the following powers:

(a) To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

(b) To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

(c) To authorize my admission to or discharge, even against medical advice, from any hospital, nursing home, residential care, assisted living or similar facility or other healthcare facility;

(d) To contract on my behalf for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;

(e) To select and discharge medical, social service, and other support personnel responsible for my care;

(f) To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

(g) To take any other action necessary to do what I authorize here, including but not limited to granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice; and pursuing any legal action in my name, and at the expense of my estate, to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

This Power of Attorney for Health Care shall give my agent the authority to make decisions about withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, Health Care Directive, and/or Advance Care Plan, or if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interest as determined by my

physician in consultation with my attorney-in-fact.

If _____ resigns or is not able, available, or willing to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term "health care" shall have the meaning set forth in Ark. Code Ann. § 20-6-102. This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

[If it becomes necessary for a court to appoint a guardian of my estate or guardian of my person, I nominate the following person for appointment [FULL NAME], who resides at [FULL ADDRESS], and whose phone number is [PHONE NUMBER].

SIGNED this ____ day of _____, 20____.

_____
Signature

We the undersigned, do hereby certify that the Declarant, _____, subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his/her request, in his/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.

1. I am a competent adult who is not named as the agent. I witnessed the declarant's signature on this form.

_____
Print Witness Name

_____
Signature of Witness

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

_____
Print Witness Name

_____
Signature of Witness

ACKNOWLEDGMENT

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 individual, _____. The individual personally appeared before me and signed above or acknowledged the signature above as his or her own on the ____ day of _____, 20____. I declare under penalty of perjury that the individual appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____

Signature of Notary Public