ADVANCE DIRECTIVE FOR HEALTH CARE OF ____________________

I, _________________________, hereby give these advance instructions on how I want to be treated by my doctors and other healthcare providers when I can no longer make treatment decisions myself. The name of the Agent I have chosen (if any) to make decisions on my behalf is listed in my Durable Power of Attorney for Health Care. I understand that if I do not choose an agent and I am deemed by my physician to no longer have capacity, my physician may choose someone to make decisions on my behalf under the Arkansas Healthcare Decisions Act. Any person chosen to make decisions on my behalf shall look to this document to determine how I want to be treated.

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 any of the following conditions** (you can check as many of these items as you want):

- ❑ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ❑ Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ❑ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on other for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ❑ 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 the declarant'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:

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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, neither witness should be the person you appointed 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: __________________

Witnesses:

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 ____________________, 201_. 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