



ARKANSAS ADVANCE DIRECTIVE

300 Werner Street
PO Box 29001
Hot Springs, AR 71903-9001
(501) 622-1000

If I should have an incurable 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.

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 for my comfort or to alleviate pain.

These life-sustaining treatments which may be withheld or withdrawn include, but are not limited to:

1. Antibiotics
2. Artificially Administered Feeding & Fluids
3. Cardiac Resuscitation
4. Respiratory Support
5. Surgery

You may also add further instructions here:

Should there be any doubt as to these directions, I appoint _____
phone: _____ as my Healthcare Proxy to decide whether life-sustaining
treatment should be withheld or withdrawn.

If the person named above cannot serve as my Healthcare Proxy, I name _____
phone: _____ as an alternate Healthcare Proxy.

If I am no longer able to make decisions regarding my medical treatment, and I am not
terminally ill or
permanently unconscious, I authorize my Health Care Proxy to make healthcare decisions for
me.

Signed _____

Print Name: _____

Signature: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____ Witness: _____

Address: _____ Address: _____