

DECLARATION OF LIVING WILL
OF

**TO my FAMILY, my PHYSICIAN, my LAWYER
AND ALL OTHERS WHOM IT MAY CONCERN**

I, _____, of _____, Arkansas, being of sound mind and over the age of 18, pursuant to, and in accordance with, the Arkansas Rights of Terminally Ill or Permanently Unconscious Act (the "Act"), codified at Arkansas Code Annotated §§ 20-17-201 et seq., do hereby voluntarily make known my desires as set forth below.

1. 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 common law and the 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 Act, to withhold or withdraw life-sustaining treatments which are no longer necessary to my comfort or to alleviate pain.

3. The life-sustaining treatments referred to in the above paragraphs which may be withheld or withdrawn include, but are not limited to: antibiotics, cardiopulmonary resuscitation, respiratory support, mechanical breathing, kidney dialysis, chemotherapy, invasive diagnostic tests, blood products, any surgery (unless necessary for my comfort or to alleviate pain), or other medications not necessary for alleviation of pain.

4. I understand that Arkansas law requires me to make my wishes regarding artificial nutrition and hydration known separately from the above directions. Therefore, I specifically DIRECT that artificial nutrition and artificial hydration may not be withheld or withdrawn, unless after consultation with my attending physician it is determined that artificial nutrition or artificial hydration cannot reasonably be expected to prolong life, or that the means of administering artificial nutrition or artificial hydration would be excessively burdensome for me or cause significant physical discomfort to me.

5. If there should be any doubt as to these directions or should any person require interpretation concerning the purpose and effect of this Declaration, I direct my attending physician to follow the instructions of that person named as my agent or attorney-in-fact in my Durable Power of Attorney for Health Care to decide whether life-sustaining treatment should be withheld or withdrawn.

