DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For Arkansas Residents

Statutory Compliant Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For Arkansas Residents

Statutory Compliant Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Arkansas Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Arkansas state legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can revoke (cancel) this directive at *any* time by: 1) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or 2) by completing a Notice of Revocation; or 3) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or 4) *by simply completing a new directive* in which you state that any prior directive is no longer valid.

You can limit your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are unable to write, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless

you direct otherwise, this directive will only be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

To complete this document, you should ***initial*** in the underlined spaces provided beside any questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

ARKANSAS DECLARATION

RELATING TO THE USE OF LIFE-SUSTAINING TREATMENT

Proxy Appointment and Personal Instructions

(AC Title 20: Subtitle 2; Chapter 17: Sub-Chap.2: §20-17-201 to §20-17-217)

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1. INTRODUCTION. *The Arkansas living will Declaration was designed to assist those wishing to refuse life-sustaining treatment in terminal or permanently unconscious conditions (§20-17-201). A* ***terminal condition*** *is defined as, "an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relative short time"(§20-17-201(11)). A* ***permanently unconscious*** *condition is defined as "a lasting condition, indefinitely without change in which thought, feeling, sensations, and awareness of self and environment are absent"(§20-17-201(6)). Life-sustaining treatment is defined as, "any medical procedure or intervention that, when administered...will serve only to prolong the process of dying or to maintain the patient in a condition of permanent unconsciousness"(§20-17-201(5)).*

FIRST DECLARATION

(*Concerning Terminal Conditions*)

2. **Regarding a Terminal Condition**. 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:

(*initial only one*)

_____ Withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

OR,

_____ Follow the instructions of:

Name of Proxy: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ whom I appoint as my Health Care Proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

3. **Regarding Artificially Provided Nutrition** (*food given through tubes or other medical devices*). In a terminal condition, it is my specific directive that nutrition:

(*initial only <u>one</u>*)

_____ may be withheld after consultation with my attending physician.

_____ nutrition may ***<u>not</u>*** be withheld.

4. **Regarding Artificially Provided Hydration** (*water given through tubes or other medical devices*). In a terminal condition, it is my specific directive that hydration:

(*initial only <u>one</u>*)

_____ may be withheld after consultation with my attending physician.

_____ hydration may ***<u>not</u>*** be withheld.

Validation and Signature

5. Signed this_____ day of _____ , 20_____

6. Signature: _____

7. Address: _____

_____

Statement and Signature of Witnesses

8. The declarant voluntarily signed this writing in my presence.

9. Witness: _____

Printed Name:_____

Address: _____

10. Witness: _____

Printed Name:_____

Address: _____

SECOND DECLARATION

(*Concerning Permanent Unconsciousness*)

11. **Regarding Permanent Unconsciousness**. If I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to:

(*initial only <u>one</u>*)

_____ withhold or withdraw life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain.

OR,

_____ Follow the instructions of:

Name of Proxy: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

12. **Regarding Artificially Provided Nutrition** (*food given through tubes or other medical devices*). It is my specific directive that nutrition:

(*initial only <u>one</u>*)

_____ may be withheld after consultation with my attending physician.

_____ nutrition may *<u>not</u>* be withheld.

13. **Regarding Artificially Provided Hydration** (*water given through tubes or other medical devices*). It is my specific directive that hydration:

(*initial only <u>one</u>*)

_____ may be withheld after consultation with my attending physician.

_____ hydration may *<u>not</u>* be withheld.

Validation and Signature

14. Signed this_____ day of _____ , 20_____

Signature: _____

Address: _____

_____

Statement and Signature of Witnesses

15. The declarant voluntarily signed this writing in my presence.

16. Witness: _____

Printed Name:_____

Address: _____

17. Witness: _____

Printed Name:_____

Address: _____