Living Will Declaration

Arkansas Surgical HOSPITAL

_____
Name of Person Signing Document

Social Security # _____

Date of Birth: _____/ _____/ _____

If I am permanently unconscious or terminally ill, and I am not able to make decisions concerning my medical treatment, I direct my physician to withhold or withdraw treatment that prolongs the process of my dying and is not necessary to my comfort.

Please put your initials by each procedure that you do NOT want:

_____ Cardiac Resuscitation (CPR)

_____ Surgery

_____ Artificially Administered Feeding & Fluids (*Feeding Tubes)*

_____ Antibiotics (*Infection Fighting Drugs)*

_____ Kidney Dialysis

_____ Respirator/Ventilator

_____ Blood Products

_____ Other: _____

This document is intended to be a LIVING WILL in accordance with the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

Signature: _____ Date: _____/ _____/ _____

_____ ___/ ___/ ___ _____ ___/ ___/ ___
Witness Signature Date Witness Signature Date

HEALTHCARE PROXY

Any time I am permanently or temporarily unable to make healthcare decisions, my HEALTHCARE PROXY will be: _____.
My Healthcare Proxy may make all decisions about:

- My Personal Care
- My Medical Care
- Hospitalization
- Whether I shall receive medical treatment or procedures, including artificial feeding and fluids, even though I may die as a result of this decision.

Such decisions will be consistent with my wishes or if my wishes are unknown, will be consistent with my best interest. This document is intended to be a durable (Healthcare) power of attorney and a declaration and proxy appointment in accord with the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

Signature: _____ Date: _____/ _____/ _____

_____ ___/ ___/ ___ _____ ___/ ___/ ___
Witness Signature Date Witness Signature Date

CHART COPY ***LIVING WILL DECLARATION***