

# ARKANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I,

(name)

hereby appoint:

(name, home address and telephone number of agent)

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as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

This Durable Power of Attorney for Health Care shall take effect in the event I become unable to make my own health care decisions. My health care agent and any alternate health care agent shall have the authority to make all health care decisions regarding any care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental health or personal care. My health care agent and any alternate agent shall also have the authority to make decisions regarding the providing, withholding or withdrawing of life sustaining treatment pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.

Optional Instructions:

If the health care agent I appoint is unable, unwilling or unavailable to act as my health care agent, then I appoint: \_\_\_\_\_

(name, home address and telephone number of alternate agent)

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Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ (year).

Signature \_\_\_\_\_

Address \_\_\_\_\_

## Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the durable power of attorney for health care willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness \_\_\_\_\_  
(sign and print name)

Address \_\_\_\_\_

Witness \_\_\_\_\_  
(sign and print name)

Address \_\_\_\_\_