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ARKANSAS DECLARATION

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 *or* 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 withhold or withdraw treatments that only prolong the process of dying and are not necessary to my comfort or to alleviate pain.

Other directions:

I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to follow the instructions of , whom I appoint as my Health Care Proxy to make medical treatment decisions on my behalf, including whether life-sustaining treatment should be withheld or withdrawn.

Signed this day of , (year).

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____
(sign and print name)

Address _____

Witness _____
(sign and print name)

Address _____