Declaration Relating to Use of Life-Sustaining Treatment

If I should have **either** an incurable or irreversible condition that will cause my death within a relatively short period of time, and I am no longer able to make decisions regarding my medical treatment, **OR** if I should become permanently unconscious, I direct my physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, and the Arkansas Emergency Medical Do Not Resuscitate Act, to:

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

[ ] Initial_____ Use every means reasonably available to sustain my life, regardless of my prognosis.

[ ] Initial_____ Withhold or withdraw CPR including cardiac compression, Endotracheal intubation, and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures **IF** I am terminally ill and unable to make my own medical decisions **OR** am Permanently Unconscious.

[ ] Initial_____ Follow the instructions of _____ , whom I appoint as my Health Care Proxy to decide whether life-sustaining treatment should be withheld or withdrawn. I understand that this Proxy shall, in consultation with my physician, have the authority to make treatment decisions for me including the withholding or withdrawal of life-sustaining treatment. If my proxy is not available, then any wishes as stated above shall be immediately followed.

Signed this _____day of _____,20____. _____
Signature

_____
Address

The declarant voluntarily signed this writing in my presence.

1) _____ _____
Witness Address

2) _____ _____
Witness Address