DECLARATION OF LIVING WILL OF

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[*Name of Declarant*]

If I should have an incurable or irreversible condition with no hope of recovery 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 Common Law and the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Additionally, 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 life-sustaining treatments that are no longer necessary to my comfort or to alleviate pain.

Section 1: Life-Sustaining Treatments

The life-sustaining treatments which **may be withheld or withdrawn** are (check all that apply):

- ☐ Cardiopulmonary Resuscitation.
- ☐ Mechanical Breathing.
- ☐ Major Surgery.
- ☐ Kidney Dialysis.
- ☐ Chemotherapy.
- ☐ Minor Surgery (unless necessary for my comfort or to alleviate pain).
- ☐ Invasive Diagnostic Tests.
- ☐ Antibiotics.
- ☐ Blood Products.
- ☐ Other Medications not Necessary for Alleviation of Pain.

Add other medical directives, if any____

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Section 2: **Artificial Nutrition and Hydration**

I understand that Arkansas law requires me to make my wishes regarding artificial nutrition and hydration known separately from the above directions. Therefore, by initialing the appropriate line(s) below, I specifically:

_______ DIRECT that **artificial nutrition may be withheld** or withdrawn after consultation with my attending physician.

_______ DIRECT that **artificial hydration may be withheld** or withdrawn after consultation with my attending physician.

SIGNED this _____________ day of ______________________________, 20____.

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Declarant's Signature

We, the undersigned, do hereby certify that the Declarant, _______________________________ subscribed this Declaration of Living Will in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

_____________________________________	_____________________________________
Witness Name Printed	Witness Name Printed
_____________________________________	_____________________________________
Witness Signature	Witness Signature
_____________________________________	_____________________________________
Address	Address
_____________________________________	_____________________________________
City, State and Zip Code	City, State and Zip Code

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.