APPOINTMENT OF HEALTH CARE AGENT; ADVANCE CARE PLAN AND ACCEPTANCE OF SURROGATE SELECTION

I, **JOHN DOE**, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me if I cannot make them for myself:

Name: JANE DOE Phone: 870-222-2222 Relation: Spouse
Address: 222 Main St., Mountain Home, Arkansas 72653

Alternate Agent: If the person named above is unwilling or unable to make health care decisions for me, I appoint as alternate.

Name: JIM DOE Phone: 870- 333-[illegible] Relation: Son
Address: 333 Main St., Mountain Home, Arkansas 72653

Quality of Life: I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is **unacceptable** to me means when I have any of the following conditions (**you can check as many of these items as you want**.)

X **Permanent Unconscious Condition**: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

x **Permanent Confusion**: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

x **Dependent in all Activities of Daily Living**: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

x **End-Stage Illnesses**: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my **quality of life becomes unacceptable** to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows: **Checking "Yes" means I WANT the treatment. Checking "No" means I DO NOT WANT the treatment.**

Yes	No	Treatment
x	☐	**CPR (Cardiopulmonary Resuscitation)**: To make the heart beat again and and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐	x	**Life Support / Other Artificial Support**: Continuous use of breathing machine. IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐	x	**Treatment of New Conditions**: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

(Continued)

☐ Yes x No **<u>Tube Feeding/IV Fluids</u>**: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.________________

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(Attach additional pages if necessary)

<u>Organ donation (Optional)</u>: Upon my death I wish to make the following anatomical gift (please mark one):

☐ Any organ tissue x My entire body ☐ Only the following organs, tissues:

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Executed on this 3rd day of January, 2013.

John Doe

JOHN DOE ("Patient")

The declarant voluntarily signed this writing in our presence. We are not related to the patient.

Jane Smith
WITNESS

Mountain Home, Arkansas
ADDRESS

John Smith
WITNESS

Mountain Home, Arkansas
ADDRESS

STATE OF ARKANSAS
COUNTY OF BAXTER

I am a Notary Public in and for the State and County named above. The person who signed this instrument is known to me to be the person who signed as the "patient". The patient and the two witnesses personally appeared before me and signed above or acknowledged the signature above as their own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: 3-2-2013

Jane Roe
Notary Public

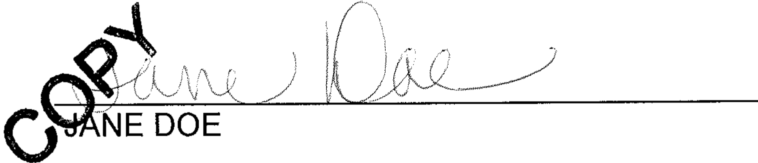
COPY

ACCEPTANCE OF SURROGATE SELECTION

COPY

I accept the appointment as surrogate for JOHN DOE and understand I have the authority to make all medical decisions for JOHN DOE, in the event that JOHN DOE is unable or unwilling to make his own medical decisions.

Executed this 3rd day of January, 2013.



JANE DOE

COPY

COPY

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- **Provide a copy to your physician(s)**
- **Keep a copy in your personal files where it is accessible to others**
- **Tell your closest relatives and friends what is in the document**
- **Provide a copy to the person(s) you named as your health care agent**

COPY