LIVING WILL DECLARATION

FOR_____ **Social Security Number**_____

I, _____, Date of Birth _____, being of sound mind, voluntarily make known my desires concerning medical treatment if I should become permanently unconscious, and or 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. I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatment, as indicated below, that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

Initial the options below which you are requesting:

_____ I direct that transfusions, antibiotics, cardiovascular regulators, cancer chemotherapeutics, anti-inflammatory medication or any other drugs administered to control a disease process to be withheld or withdrawn;

_____ I direct that any and all nutrition given artificially, either intravenously, by nasogastric (into the stomach via the nose) or gastrostomy feeding (via a hole in the stomach) tube or any other means other than voluntarily taken by mouth, be withheld or withdrawn;

_____ I direct that any and all hydration given artificially, either intravenously, by nasogastric (into the stomach via the nose) or gastrostomy feeding (via a hole in the stomach) tube or any other means other than voluntarily taken by mouth, be withheld or withdrawn;

_____ I direct that Cardio-pulmonary resuscitation be withheld;

_____ I direct that Surgery, either major or minor, be withheld;

_____ I direct that invasive or investigational procedures, including intubation, tests, and needle punctures, be withheld or withdrawn;

_____ I direct that any and all types of mechanical breathing be withheld or withdrawn;

_____ I direct that Dialysis be withheld;

_____ I further direct that any comfort care that I receive shall be limited to pain medication.

_____ _____

Signed this _____day of _____, 20 _____.

_____
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 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, having a full understanding of what was being signed, and that his/her signature was voluntary.

Signed this _____day of _____, 20 _____.

_____ _____
Witness Signature Witness Signature

_____ _____
Address Address

_____ _____
Address Address

JEFFERSON REGIONAL MEDICAL CENTER
LIVING WILL