STATE OF ARKANSAS
HEALTH CARE ATTORNEY IN FACT
WILL TO LIVE FORM

I, ____,
(Your name)

Address ____
(Your address)

City _______________________________ State ____________ Zip Code ___________

Telephone ___________________________ Other _______________________________
(Your telephone number(s), please include area code)

designate ____
(Attorney in Fact's name)

Address ____
(Attorney in Fact's address)

City _______________________________ State ___________ Zip Code _____________

Telephone ___________________________ Other ________________________________
(Attorney in Fact's telephone number(s), please include area code)

as my health care attorney in fact to make any health care decisions for me as authorized in this document consistent with the instructions below. If the person I designate above refuses or is not able to act for me, I designate the following persons (each to act alone and successively, in the order named):

A. ____
(Successor Attorney in Fact's name)

Address ____
(Successor Attorney in Fact's address)

City ____________________________ State ______________ Zip Code ____________

Telephone _________________________ Other _____________________________
(Successor Attorney in Fact's telephone number(s), please include area code)

B. ____

(Second Successor Attorney in Fact's name)

Address ____

(Second Successor Attorney in Fact's address)

City ________________________________ State ____________ Zip Code ___________

Telephone ___________________________ Other ______________________________

(Second Successor Attorney in Fact's telephone number(s), please include area code)

as my health care attorney in fact(s) to make any health care decisions for me as authorized in this document consistent with the instructions below. This designation shall become effective only when I become incapable of making and communicating my own health care decisions. Any prior designation is revoked.

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care agent to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care agent to provide me with food and fluids, orally, intravenously, by tube, or by other artificial means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death. I direct that the following be provided:

- The administration of medication;
- Cardiopulmonary resuscitation (CPR); and
- The performance of all other medical procedures, techniques, and technologies, including surgery,

All to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions. I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

The instructions in this document are intended to be followed even if suicide is alleged to be attempted at some point after it is signed.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the quality of my life. I reject any action or omission that is intended to cause or hasten my death. I direct my health care provider(s) and health care agent to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my agent, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If I have an incurable terminal illness or injury, and I will die imminently, meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me, the following may be withheld or withdrawn: **(Be as specific as possible; SEE SUGGESTIONS):**

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(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition, meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me, the following may be withheld or withdrawn. **(Be as specific as possible; SEE SUGGESTIONS):**

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(Cross off any remaining blank lines).

C. **OTHER SPECIAL CONDITIONS**: **(Be as specific as possible; SEE SUGGESTIONS):**

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(Cross off any remaining blank lines.)

IF I AM PREGNANT

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

____

Signature of Principal

Signed this ______________________ day of __________________________, _____________

Signature____

Address____

The declarant voluntarily signed this writing in my presence.

Signature of First Witness ____

Address of First Witness ____

Signature of Second Witness ____

Address of Second Witness ____

Form prepared 2005

For additional copies of the Will to Live, visit www.nrlc.org or contact Arkansas Right to Life