Place MR Label Here
MR#:
Patient's Name:
Patient's Address:

Print your name here: ______________________

Your birth date: ______________________

My Durable Power of Attorney for Healthcare

Choose who you want to make medical decisions for you if you cannot (this person is called your healthcare agent)

My first choice:

✓ We will ask this person first if you cannot make medical decisions for yourself.

____
First Name Last Name

____
Street Address

____
City State Zip Code

____
Home Phone Number Mobile Phone Number

Relationship to you: ______________________

My next choice:

(not required)

✓ We will only ask this person if your first choice is not able to do it, or we are unable to contact them.

____
First Name Last Name

____
Street Address

____
City State Zip Code

____
Home Phone Number Mobile Phone Number

Relationship to you: ______________________

Sign this document

In the order listed, I want the people above to make decisions for me if I am not able to myself. I understand that if I chose my spouse, and we later legally separate or get divorced, that my spouse will automatically lose the right to make decisions for me.

____
Your signature Date Time

Witness Signatures & Notary box on back →

Place MR Label Here
MR#:
Patient's Name:
Patient's Address:

Either have two witnesses sign this <u>OR</u> have it notarized (see below)

Witness #1: I am a competent adult. I am not one of the people listed above. I am not the patient's healthcare provider. I witnessed the patient sign this form.

____
Signature of Witness #1 Date Time

Witness #2: I am a competent adult. I am not one of the people listed above, nor am I the patient's healthcare provider. I am not related to the patient, and I am not entitled to get anything from the patient's estate. I witnessed the patient sign this form.

____
Signature of Witness #2 Date Time

For Notaries to Fill Out

Do not notarize if witnesses have signed above

State of Arkansas, County of ____________________

I am Notary Public in and for the State and County named above. The person who signed this form is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is signed above. This person personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

____
Date Commission Expires

____
Signature of Notary Public Date Time

Advance Directive