(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

Print your name here: _____

Your birth date: _____

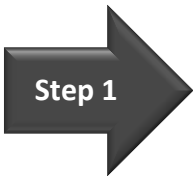
UAMS
University of Arkansas for Medical Sciences

My Living Will

What this form does: If you cannot make decisions yourself, this form tells your doctors and caregivers what you want so that they do not have to guess. **This form applies only if your health problems are so bad that you cannot make decisions for yourself.**

What is life-support treatment? Life-support treatment means medical care that keeps you alive when some part of your body fails. Some of the most common life-support treatments are

- **CPR** (to try to restart your heart and lungs when they have stopped working)
- **Breathing machines** (to help keep you breathing if you cannot on your own)
- **Dialysis** (to clean your blood if your kidneys stop working)
- **Artificial nutrition** (to feed you through tubes if you cannot swallow)



What care do you want if you become so sick that you are likely to die soon?

If my doctors decide I am likely to die soon and life-support treatment would only delay my death, then I want the following: (check **only one** of the boxes)

- ☐ I want my doctors to do everything medically reasonable to keep me alive.
- ☐ I **do not** want life-support treatment. If it has been started, I want it stopped so I die a natural death.
- ☐ I want my doctors and the person I have chosen as my healthcare agent to discuss and decide what is best for me on every issue.
- ☐ I have the following specific wishes: _____

_____

_____

✓Your **healthcare agent** is the person you listed in the Durable Power of Attorney for Healthcare.

What care do you want if you are not expected to recover from severe brain injury?

If my doctors do not expect me to recover enough to be aware of and interact with the world around me, I want the following:
(check **only one** of the boxes)

- ☐ I want my doctors to do everything medically reasonable to keep me alive.
- ☐ I **do not** want life-support treatment. If it has been started, I want it stopped so I die a natural death.
- ☐ I want my doctors and the person I have chosen as my healthcare agent to discuss and decide what is best for me on every issue.
- ☐ I have the following specific wishes: _____

_____

_____

✓**Severe brain injury** includes things like

- being in a coma or in a vegetative state that you will not come out of
- or having end-stage dementia

Continues on the next page →

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Step 3

If there is anything else you would like to tell your doctors, caregivers, or family, write it on these blank lines

_____
_____
_____
_____
_____
_____

Sign this document

I want my doctors, my healthcare agent, and any other caregiver to follow my wishes stated in this form. I intend for this to be a living will under the Arkansas Healthcare Decisions Act. I understand that I can change my mind at any time by creating a new living will or by telling my doctors, my healthcare agent, or my caregivers that my wishes have changed.

_____

Your Signature Date Time

Step 4

Either have two witnesses sign this <u>OR</u>
have it notarized (have the notary fill out the bottom of this page.)

Witness #1: I am a competent adult. I am not the patient's healthcare agent, or 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 the patient's healthcare agent. I am not related to the patient, and I am not entitled to anything from the patient's estate. I am not the patient's healthcare provider. 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 this form

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 my commission expires

_____

Signature of Notary Public Date Time