## APPOINTMENT OF HEALTH CARE AGENT

(Arkansas)

I,, give my ag	ent named below permission to make health care
decisions for me if I cannot make decisions for myself, inc for myself if able. If my agent is unavailable or is unable of the agent's place.	luding any health care decision that I could have made
Agent:	Alternate:
Name	Name
Address	Address
City State Zip Code	City State Zip Code
( ) Area Code Home Phone Number	() Area Code Home Phone Number
( ) Area Code Work Phone Number	() Area Code Work Phone Number
( ) Area Code Mobile Phone Number	() Area Code Mobile Phone Number
Patient's name (please print or type)  Date	Signature of patient (must be at least 18 or emancipated minor)
To be legally valid, either block A or block B must be prope	erly completed and signed.
Block A Witnesses (2 witnesses required)	
I am a competent adult who is not named above.	
I witnessed the patient's signature on this form.	Signature of witness number 1
2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.	Signature of witness number 2
Block B Notarization	
STATE OF ARKANSAS COUNTY OF	
I am a Notary Public in and for the State and County named above. The proved to me on the basis of satisfactory evidence) to be the person we appeared before me and signed above or acknowledged the signature apatient appears to be of sound mind and under no duress, fraud, or undured the signature of the signatu	hose name is shown above as the "patient." The patient personally above as his or her own. I declare under penalty of perjury that the
My commission expires:	
	Signature of Notary Public