Patient Sticker

APPOINTMENT OF HEALTHCARE AGENT

PLEASE NOTE: THIS DOCUMENT MUST BE SIGNED AND EITHER WITNESSED OR NOTARIZED TO BE LEGALLY BINDING

I, _____, hereby appoint the person named below as my Healthcare Agent and give my agent permission to make health care decisions for me if I cannot make such decisions for myself. The power to make such healthcare decisions shall apply to any healthcare decision that I could have made for myself if I were able. If my named agent is unavailable or is unable to serve for any reason, I appoint the alternate named herein to take my agent's place as my healthcare agent:

AGENT:

_____
Printed Name

_____
Address

_____
City State Zip

_____
List All Applicable Phone Numbers

ALTERNATE:

_____
Printed Name

_____
Address

_____
City State Zip

_____
List All Applicable Phone Numbers

Signature:

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness can be the person you appointed as your agent, and at least one of the witnesses cannot be someone who is not related to you or entitled to any part of your estate.

Signature: _____ Date: _____

(Patient)

Witnesses:

We, the undersigned, do hereby certify that the above named Declarant signed this Advance Directive in our presence, and we, at the Declarant's request, in the Declarant's presence, and in the 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 and that the Declarant's signature was voluntary.

_____	_____
Signature	Witness
_____	_____
Printed Name	Printed Name
_____	_____
Address	Address
_____	_____
Address	Address

OR

Notary:

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient 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.

My Commission Expires:

_____

_____
Notary Public

ACCEPTANCE OF SURROGATE SELECTION

I accept the appointment as surrogate for _____
(Patient Name)
and understand I have the authority to make all medical decisions the Patient could have personally made.

_____ _____
Signature of Surrogate Date and Time

CSN001