APPOINTMENT OF
HEALTHCARE AGENT

I_____, hereby appoint the persons 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 including 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

ALTERNATE1:

_____
Printed Name

_____
Address

_____
City State Zip

_____
List All Applicable Phone Numbers

ALTERNATE 2:

_____
Printed Name

_____
Address

_____
City State Zip

_____
List All Applicable Phone Numbers

ALTERNATE3:

_____
Printed Name

_____
Address

_____
City State Zip

_____
List All Applicable Phone Numbers

ALTERNATE 4:

_____
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 related to you or entitled to any part of your estate.

Signature: _____ Date: _____
(Patient)

Witnesses:

1. I am a competent adult who is not the named Agent above. I witnessed the patient's signature.

_____
Witness Signature -1

2. I am a competent adult who is not the named Agent above. I am not related to the patient by blood, marriage, or adoption and upon patient's death, I would not be entitled to any portion of the patient's estate under any existing will, codicil or by operation of law. I witnessed the patient's signature.

_____
Witness Signature -2

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