ARKANSAS HEALTH CARE PROXY

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APPOINTMENT OF HEALTH CARE AGENT

(Arkansas)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

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 properly completed and signed.

Block A Witnesses (2 witnesses required)

1. 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 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: _____

_____ Signature of Notary Public

CRITICAL STEP:
SHARE YOUR COMPLETED DOCUMENT!

Your document is only helpful if people know where to find it when it is needed. It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

WHO NEEDS A COPY OF YOUR DOCUMENT?

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

HOW TO SHARE YOUR DOCUMENT

1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address*

   Create your free Cake account: www.joincake.com/share-free

2) **Or, print** and provide copies to everyone who needs one

WHY PLAN & SHARE WITH CAKE?

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address*

Create your free Cake account: www.joincake.com/share-free

** Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*