INSTRUCTIONS

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

PRINT YOUR NAME

Name:_____
(Last) *(First)* *(Middle Initial)*

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

Name:_____

Address: _____

_____ Zip Code: _____

Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

ADD PERSONAL INSTRUCTIONS (IF ANY)

Additional instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT

Name: _____

Address: _____

Name: _____

Address: _____

SIGN AND DATE THE DOCUMENT

Signed: _____

Date: _____

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: _____

Address: _____

Witness 2:

Signed: _____

Address: _____

Courtesy of **Partnership for Caring, Inc.** 10/99
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455

INSTRUCTIONS

FLORIDA LIVING WILL

PRINT THE DATE

PRINT YOUR NAME

Declaration made this _____ day of _____, _____,
(day) *(month)* *(year)*
I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that:

PLEASE INITIAL EACH THAT APPLIES

If at any time I am incapacitated and

_____ I have a terminal condition, or
_____ I have an end-stage condition, or
_____ I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

I wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on my behalf:

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

ADD PERSONAL INSTRUCTIONS (IF ANY)

Additional instructions (optional):

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

SIGN THE DOCUMENT

Signed: _____

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: _____

Address: _____

Witness 2:

Signed: _____

Address: _____

Courtesy of **Partnership for Caring, Inc.** 6/00
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455