## LIVING WILL

Declaration made this day of, (20), 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, if at any time I am incapacitated and:
(initial) I have a terminal condition, or
(initial) I have an end stage condition, or
(initial) I am in a persistent vegetative state, and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery fro such a condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted die naturally with only the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:
Name:
Address:
3
Phone:
I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.
Additional Instructions (optional):

Witness Signatures:	
	Signature
	Printed Name
-	Address
	Phone
	Signature
· · · · · · · · · · · · · · · · · · ·	Printed Name
	Address
	Phone

## DESIGNATION OF HEALTH CARE SURROGATE

I,	, designate as my health care surrogate under S. 765.202, Florida Statutes:
Name	
Addre	ss:
Phone	
If my	haalth assa symmetria met willime able an massaubly swillely to make the section of
	health care surrogate is not willing, able, or reasonably available to perform his or her duties, I ate as my alternate health care surrogate:
Name:	
Addre	38:
Phone	
	INSTRUCTIONS FOR HEALTH CARE
I autho	orize my health care surrogate to: (Initials required in blank spaces below.)
1	Receive any of my health information, whether oral or recorded in any form or medium, that:
	1. Is created or received by a health care provider, health care facility, health plan, public health, employer, life insurer, school or university, or health care clearinghouse; and
	2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.
I furth	er authorize my health care surrogate to:
	Make all health care decisions for me, which means he or she has the authority to:
	3. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
	4. Apply on my behalf for private, public, government, or veteran's benefits to defray the cost of health care.
	5. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
	_6. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

specific instructions and restrictions.						
While I have decision making capacity, my wishes are controlling and my physician and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.						
To the extent that I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.						
This health care surrogate designation is not affected by my subsequent incapacity except as provided in Chapter 765, Florida Statutes.						
Pursuant to section 765.104, Florida Statutes, I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:						
1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation;						
2. Physically destroying this designation through my own action or by that of another person in my presence and under my direction;						
3. Verbally expressing my intention to amend or revoke this designation; or						
4. Signing a new designation that is materially different from this designation.						
My health care surrogate's authority becomes effective when my primary physician determines that I am mable to make my own health care decisions unless I initial either or both of the following boxes:						
f I initial this box [] my health care surrogate's authority to receive my health information takes affect immediately.						
f I initial this box [] my health care surrogate's authority to make health care decisions for meakes effect immediately. Pursuant to section 765.204(3), Florida States, any instructions of health care decisions I make, either verbally or in writing, while I possess capacity shall supercede any instructions or health care decisions made by my surrogate that are in material conflict with those made by me.						
Signatures: Sign and date the form here:						
Date Sign your name						
Address Print your name						
City, State						

Signatures of withe	esses:		
First Witness		Second Witness	
	Print name		Print name
	Address		Address
	City, State		City, State
***	Signature		Signature
	Date		Date

## **Uniform Donor Form**

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:								
	(a)	any needed	l organs or parts					
		or education					tion, therapy,	medical
	7						_	
	(c)		or anatomical stud				— wishes, if any	:
							_	
	-						-	
Signed	by the do	nor and the f	ollowing witness	es in the pres	sence of ea	ch other:		
Donor's	s Signatur	e			Donor	's Date of Bir	rth	
Date Si	gned		_City and State_					
Witness				Witness _				
Street A	ddress			Street Add	iress			
City			_ State	City		St	ate	

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).