

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medical probability of my recovery from such a condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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:

Name: _____

Address: _____

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: _____

Address: _____

Phone: _____

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name: _____

Address: _____

Phone: _____

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to: (Initials required in blank spaces below.)

_____ 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 further 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.

Signatures of Witnesses:

First Witness

_____ Print name
_____ Address
_____ City, State
_____ Signature
_____ Date

Second Witness

_____ Print name
_____ Address
_____ City, State
_____ Signature
_____ 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 organs or parts

(b) _____ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any:

Signed by the donor and the following witnesses in the presence of each other:

Donor's Signature _____ Donor's Date of Birth _____

Date Signed _____ City and State _____

Witness _____

Street Address _____

City _____ State _____

Witness _____

Street Address _____

City _____ State _____

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).