

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE
(Durable Power of Attorney for Healthcare)

In the event that I, **Name** _____, have been determined by my physician(s) 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:**

Name: _____ / Relationship _____

Address: _____

Phone #: (w) _____ (h) _____ (c) _____

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

Name: _____ / Relationship _____

Address: _____

Phone #: (w) _____ (h) _____ (c) _____

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.

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:

Name: _____ / Relationship _____

Address: _____

My Signature: _____ Date: ___/___/___

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness #1: Name: _____

Signature: _____ Date: ___/___/___

Address: _____

Witness #2: Name: _____

Signature: _____ Date: ___/___/___

Address: _____



FLORIDA LIVING WILL

Declaration made this ____ day of _____, 20 ____

I, **Name** _____, 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:

If at any time I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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.

Additional instructions (optional): _____

If I am pregnant and this is known to my physician(s), this Living Will shall have no force or effect during the course of my pregnancy.

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

My Signature: _____ **Date:** ___/___/___

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness #1: Name: _____

Signature: _____ Date: ___/___/___

Address: _____

Witness #2: Name: _____

Signature: _____ Date: ___/___/___

Address: _____

