

# FLORIDA ADVANCE DIRECTIVE OF

(YOUR NAME) \_\_\_\_\_

## PART I: 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 mentally or physically incapacitated and

\_\_\_\_\_ I have a terminal condition caused by injury or illness that has no cure and from which doctors expect me to die even with medical treatment. Life-sustaining treatments will only prolong the dying process, or

\_\_\_\_\_ I am in a persistent vegetative state for a period of 60 consecutive days, (i.e. unconscious with no hope of regaining consciousness even with medical treatment. My body may move and my eyes may be open, but as far as anyone can tell, I am unable to think or respond), 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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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 alleviate pain.

I do \_\_\_\_\_, I do not \_\_\_\_\_ want life-sustaining treatment including CPR. If my condition is determined to be terminal or I am in a persistent vegetative state for a period of 60 days, life-sustaining treatment is to be stopped if already started.

I do \_\_\_\_\_, I do not \_\_\_\_\_ want nutrition and hydration (food and water) withheld or withdrawn because it is my belief that the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that 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 honor this declaration.

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

Additional Instructions:

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## PART II: Designation of Health Care Surrogate

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

(1<sup>st</sup>) Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Tel: \_\_\_\_\_

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

(2<sup>nd</sup>) Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Tel: \_\_\_\_\_

I fully understand that this designation will permit my designee(s) to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or 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:

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## PART III: Uniform Donor Form

I hereby make the following anatomical gift, if medically acceptable, to take effect upon my death. The marks below indicate my desires:

I give:

- (a) \_\_\_\_ **YES**    \_\_\_\_ **NO**    any needed organs for the purpose of living transplantation
- (b) \_\_\_\_ **YES**    \_\_\_\_ **NO**    my body for anatomical study if needed.
- (c) \_\_\_\_ **YES**    \_\_\_\_ **NO**    autopsy performed if requested by physician

## PART IV: Signature of Grantor

I understand the full import of this directive that includes the following: Living Will, Designation of Health Care Surrogate (medical power of attorney), and Uniform Donor Form. I am emotionally and mentally competent to make this directive.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature of grantor: \_\_\_\_\_

Address of grantor: \_\_\_\_\_

\_\_\_\_\_

## PART IV: Witnessing Procedure

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.

Signature of witness #1: \_\_\_\_\_

Address of witness #1: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of witness #2: \_\_\_\_\_

Address of witness #2: \_\_\_\_\_ Date: \_\_\_\_\_

- OR -

## State of Florida

Highlands County

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen years of age or older, and acknowledged that he/she dated and signed this document.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature: \_\_\_\_\_

Date commission expires: \_\_\_\_\_