Florida Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[   ]   Living Will
[   ]   Selection of Health Care Agent (Designation of Health Care Surrogate)
[   ]   Designation of Primary Physician
[   ]   Organ Donation

Living Will

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 your choices)**:

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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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

Additional Instructions **(optional)**:

Selection of Health Care Agent
(Designation of Health Care Surrogate)

In the event that I have been determined to be incapacitated to provide express and informed consent to withholding, withdrawal, or continuation of life-prolonging procedures or to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to desig-

nate as my surrogate for health care decisions and to carry out the provisions of my living will (if I have adopted one) _____ (name), of _____ (address).

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent

_____ (name of individual you choose as first alternate agent)
_____ (address)

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, 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 my primary physician. My failure to designate a surrogate shall not invalidate my living will.

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[   ] any organs or parts **OR**
[   ] eyes   [   ] bone and connective tissue   [   ] skin
[   ] heart   [   ] kidney(s)   [   ] liver
[   ] lung(s)   [   ] pancreas   [   ] other _____
for the purposes of:

[   ] any purpose authorized by law **OR**
[   ] transplantation   [   ] research   [   ] therapy
[   ] medical education   [   ] other limitations _____

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**
[   ] Living Will
[   ] Selection of Health Care Agent (Designation of Health Care Surrogate)
[   ] Designation of Primary Physician
[   ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____   Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____
On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent (Surrogate)

I accept my appointment as Health Care Agent (Surrogate).

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent (Surrogate).

Signature _____ Date _____