Living Will

Declaration made this _____ day of _____, 2____, 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

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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

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 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 _____
Street Address _____
City _____ State _____ Phone _____

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

Additional Instructions (optional): _____
_____
_____
_____
_____

(Signed) _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Definitions for terms on the Living Will form:

"End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

"Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

"Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined 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 _____
Street Address _____
City _____ State _____ Phone _____
Phone: _____

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

Name _____
Street Address _____
City _____ State _____ Phone _____

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; 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 (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 _____
Name _____

Signed _____

Date _____

Witnesses 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

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).

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

Health Care Advance Directives

I, _____
have created the following Advance Directives:

___ Living Will

___ Health Care Surrogate Designation

___ Anatomical Donation

___ Other (specify) _____

---------- FOLD ----------

Contact:
Name _____

Address _____
_____
_____

Phone _____

Signature _____ Date _____