FLORIDA LIVING WILL DECLARATION
AND HEALTH CARE SURROGATE

On this ___ day of _________, 20__, I, (*Print Name*)_____________________________

of: (Mailing Address)____

(City and State)__________________________________ (Zip Code)_______________

Phone: (_____)__________________________ Date of Birth:_____________

E-Mail Address: ___________________________________

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

_____ (Initial) I do not want to be tube fed

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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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

Address____Zip_______________________

Alternate: Name____________________________ Phone (____)_____________________

Address____Zip_______________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. I designate my health care surrogate as my personal representative under 45 CFR § 164.504(g), a portion of the regulations implementing the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), for all health care-related decisions.

____
Declarant's Signature

________________________________ ________________________________
1 Witness Signature # 2 Witness Signature

________________________________ ________________________________
Address Address

Before me, on this ____ day of _________ 20___ , personally appeared :

Declarant _______________________ whose I.D. is ______________________________

#1 Witness______________________ whose I.D. is ______________________________

#2 Witness______________________ whose I.D. is ______________________________

to be the Declarant and Witnesses, respectfully, whose names are signed to the forgoing instrument, and who, in the presence of each other, did freely subscribe their names to the Declaration (Living Will) on this date, and that each was over the age of majority and of sound mind.

____________________________________ My Commission Expires: _______________
Notary Public

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.