

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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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

 Address
 Presence: Physical ___ Online ___

The foregoing instrument was acknowledged before me on this ___ day of _____
 20___, by:

Declarant _____ whose I.D. is _____

#1 Witness _____ whose I.D. is _____

#2 Witness _____ whose I.D. is _____

the Declarant and Witnesses, respectfully, whose names are signed to the forgoing instrument, and who 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.