

# Advance Directives

Provided By



## LIVING WILL

If I have a terminal condition, 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is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would only serve to artificially prolong the process of dying, and that I be permitted to die naturally with only the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, and I further authorize an end of life care facility (Hospice) to honor these directives. In this condition, I do not want nutrition and hydration to be given unless it is for comfort care.

## ORGAN DONATION

I wish to be an organ donor.  Yes  No

## DESIGNATION OF HEALTH CARE SURROGATE

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment

I appoint a SURROGATE to act on my behalf and follow my wishes.

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

In the event that my surrogate is not able to perform these functions I hereby designate an ALTERNATE SURROGATE

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

Additional Instructions: \_\_\_\_\_  
\_\_\_\_\_

I willingly and voluntarily declare my Living Will and Designation of Health Care Surrogate

\_\_\_\_\_  
Print Name Signature Date

\_\_\_\_\_  
Witness Witness

(A WITNESS can be any employee or any person watching the signature. A witness can be one but not two relatives, but never the surrogate -- Per FL Statutes)  
Revised - March 2006