# ADVANCE DIRECTIVES

I voluntarily make this advance directive (surrogate designation **and/or** living will) by signing or marking it, or instructing that it be signed for me in my presence. I understand I may activate either, both or neither of the two parts of the form, and in any case I can change my mind later. I do this because I want to choose how I will be treated by my physicians and other healthcare providers. If there comes a time when I am unable to communicate or make my own healthcare decisions, I direct all those involved with my care to honor this document. I further affirm that these declarations are not being made as a condition of treatment or admission to a Public Health Trust facility.

## Part 1 – Healthcare Surrogate Designation (to make decisions for me if I am not able to)

Florida law secures the right of patients to appoint others to make healthcare decisions if they are unable to. Therefore, in the event it is determined that I am not able to provide informed consent for medical treatment, including but not limited to surgical and diagnostic procedures and decisions about receiving, withholding or withdrawing medical procedures or other treatments, I designate a healthcare surrogate to make choices for me according to his/her understanding of my wishes and values. I recognize the importance of talking to my surrogate about these matters. I further authorize my surrogate to apply for public benefits and to authorize my admission, discharge or transfer to or from any health care facility.

| **Primary Healthcare Surrogate** | **Alternate Healthcare Surrogate** (if primary surrogate is unwilling or unable to serve) |
|---|---|
| Name: | Name: |
| Address: | Address: |
| | |
| Phone: Email: | Phone: Email: |

## Part 2 – Living Will Declaration (to say that I do not want to artificially prolong the process of dying)

If I am incapacitated and suffer from a terminal illness, end-stage condition, or 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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the medication or medical procedure(s) deemed necessary to provide me with comfort care or to reduce or eliminate pain. It is my intention that this declaration be honored by my family, surrogate and physicians as the final expression of my legal right to refuse treatment and to accept the consequences of such refusal.

**Agree to Living Will** _____ (Initials) **OR** **Do not agree to Living Will at this time** _____ (Initials)

**Additional instructions to my health care team**: _____

_____

Patient Signature: _____

Print name_____ Date_____

NOTE TO WITNESSES: **The person designated as surrogate cannot be a witness.** At least one witness shall not be the spouse or blood relative of the person signing the living will.

Witness signature: _____ Witness signature: _____

Print Name: _____ Print Name: _____

Date: _____ Date: _____