INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

PLEASE INITIAL EACH THAT APPLIES

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

FLORIDA LIVING WILL

Declaration made this _____ day of _____, _____
(day) (month) (year)

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 incapacitated and

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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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

Address: _____

_____Zip Code:_____

Phone: _____

Produced for the Florida Developmental Disabilities Council
By Program Design, Inc. 5/03

FLORIDA LIVING WILL (CONTINUED)

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

I wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on my behalf.

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

ADD PERSONAL INSTRUCTIONS (IF ANY)

Additional Instructions (optional):

SIGN THE DOCUMENT

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

Signed: _____

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1::

Signed: _____

Address: _____

Witness 2:

Signed: _____

Address: _____

Courtesy of **Partnership for Caring, Inc** 6/00
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455