INSTRUCTIONS

Part One. Designation of Health Care Surrogate

PRINT YOUR NAME

Name: ____
(Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

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

Name: ____

Address:____

_____________________________________ Zip Code: ____________

Phone: ____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

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

Name: ____

Address:____

________________________________ Zip Code: ____________

Phone: ____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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Additional instructions (optional):

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INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

INITIAL EACH THAT APPLIES

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Part Two. Declaration

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

(initial all that apply)

_______ 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.

My failure to designate a health care surrogate in Part One shall not invalidate this declaration.

ORGAN DONATION (OPTIONAL)

INITIAL ONLY ONE OF THE FOUR OPTIONS

ORGAN DONATION (OPTIONAL)

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (initial one choice below):

______ any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;

______ only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education:

____

____

____

______ my body for anatomical study if needed. Limitations or special wishes, if any:

____

____

____

IF YOU HAVE ALREADY ARRANGED TO DONATE YOUR ORGANS TO A SPECIFIC DONEE, INITIAL THIS OPTION, AND INDICATE THE DETAILS OF YOUR ARRANGEMENT HERE

______ I have already arranged to donate

______ Any needed organs, tissues, or eyes,

______ The following organs, tissues, or eyes:

____

____

____

to the following donee:_________________________________

Phone:____

Address:____

___________________________________ Zip Code:__________

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Part Three. Execution

PRINT YOUR NAME

I, ____
understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

SIGN AND DATE THE DOCUMENT

Signed: ____

Date: ____

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: ____

Address: ____

____

Witness 2:

Signed: ____

Address: ____

____

OPTIONAL

PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT

(Optional) I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name: ____

Address: ____

____

Name: ____

Address: ____

____

- *Register your Estate Planning Documents for no fee at www.TheUSWillRegistry.Org*
- *It is suggested that you have your attorney review this form to be assured that it meets all your current state requirements*

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You Have Filled Out Your Health Care Directive, Now What?

1. Your *Florida Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your surrogate and alternate surrogate, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your surrogate(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning. *www.TheUSWillRegistry.org* is a free online registry for all your estate planning documents.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Florida document.

7. Be aware that your Florida document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one.

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free InfoLine
$64	helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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