LIVING WILL DECLARATION FORM

Declaration made this _____ day of _____, _____.
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 both mentally and physically incapacitated

_____ and I have a terminal condition
(INITIAL)
or _____ and I have an end-state condition
(INITIAL)
or _____ and I am in a persistent vegetative state
(INITIAL)

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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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

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

ADDITIONAL INSTRUCTIONS (optional): _____
_____
_____

Signed: _____

Witness: _____ Witness: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____

HEALTH CARE SURROGATE DESIGNATION FORM

Name _____
LAST FIRST MIDDLE

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:

Name: _____
Address: _____
Phone Number: _____

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

Name: _____
Address: _____
Phone Number: _____

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 from a health care facility.

Additional instructions (optional):_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. 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:_____
Signed:_____ Date: _____
Witness: 1._____ Witness: 2._____

- Witnesses cannot be designated surrogate or alternate. One of the witnesses cannot be a spouse or blood relative.

ACCEPTANCE OF SURROGATE DESIGNATION

I, _____, do hereby accept responsibility to act as health care surrogate for _____ should he/she become incapacitated.

Current Address: _____
Signed: _____ Date:_____

FLORIDA
DO NOT RESUSCITATE ORDER
(Please use ink)

Patient's Full Legal Name_____
(Print or Type Name) (Date)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn. (**If not signed by patient, check applicable box**):

☐ Surrogate ☐ Proxy (both as defined in Chapter 765, F.S.)
☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

Pursuant to s. 401.45, F.S., a copy or original of this DNRO may be honored by hospital emergency services, nursing homes, assisted living facilities, home health agencies, hospices, adult family-care and emergency medical services.

DH Form 1896, Revised February 2000

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(Signature of Physician) (Date) Telephone Number (Emergency)

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(Print or Type Name) (Physician's Medical License Number)

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DH Form 1896, Revised February 2000

FLORIDA
DO NOT RESUSCITATE ORDER
(Please use ink)

Patient's Full Legal Name_____
(Print or Type Name) (Date)

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☐ Court appointed guardian ☐ Durable power of attorney (pursuant to Chapter 709 , F.S.)

_____
(Applicable Signature) (Print or Type Name)