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:_____

Suggested form of a Living Will, Florida Statutes Section 765.303

A living will may, BUT NEED NOT, be in the following form:

Living Will

Declaration made this _____ day of _____ 2 ____, 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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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 _____
City _____ State ____ Zip _____
Phone _____

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

Additional Instructions (optional):

(Signed): _____

Witness _____ Witness _____
Street Address _____ Street Address _____
City, State & Zip _____ City, State & Zip _____
Phone _____ Phone _____

The principal's failure to designate a surrogate shall not invalidate the living will.

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

State of Florida
DO NOT RESUSCITATE ORDER

(please use ink)

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

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
- ☐ Court appointed guardian
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ 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)

DH Form 1896, Revised December 2004

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)

DH Form 1896,Revised December 2004 - eForms

State of Florida
DO NOT RESUSCITATE ORDER

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

OFFICIAL FLORIDA ORGAN DONOR REGISTRATION FORM

ORGAN AND TISSUE DONOR REGISTRATION FORM
PLEASE PRINT OR TYPE

State Driver License #

_____ _____

Social Security #

_____

Date of Birth (ex. 01/15/2000)

_____ **Sex:**_____**M** _____**F**

Name _____

Address _____

City _____ **State** _____

Zip _____

Signature of Donor

_____

Date signed _____

In the hope that I may help others, I hereby make this organ and tissue gift, If medically acceptable, to take effect upon my death. The words and marks (or notations) below indicate my desires. *Default* choice is (a).
I give:
(a) ☐ **any needed organ or tis**
(b) ☐ **only the following organs or tissue for the purpose transplantation, therapy, medical research or education:**
_____
(c) ☐ **my body for anatomical study if need**

Limitations or special wishes, if any, list below:
_____

NEAREST RELATIVE INFORMATION

Name _____

Address _____

City _____ **State** _____ **Zip** _____

Telephocne # (_____) _____

WITNESS INFORMATION

Witness _____

Date signed _____

Witness (Parent or Guardian if under 18) _____
Date signed _____

This is a legal document under the Uniform Anatomical Gift Act or similar laws, Chapter 765, Part V Florida Statutes. For more information, visit the Agency for Health Care Administration on the web at http://www.fdhc.state.fl.us/.

Sponsored by Agency for Health Care Administration and Department of Highway Safety and Motor Vehicles
2727 Mahan Drive - MS 37 Tallahassee, FL 32308

ADVANCE DIRECTIVE WALLET CARD

It's important that your health care provider know that you have executed an advance directive. It's also important for any treating physician to be aware that you have an advance directive. A wallet card is one way to do this. Fill out the card, then cut it out and carry it with you at all times.

To fold the card to fit in your wallet, follow these steps:

*Step 1 - Cut the **outer border** of the card below.*

*Step 2 - Fold on the **dotted line** first with words facing out.*

*Step 3 - Fold on the **solid line** so the side with "Notice to Health Care Providers" is on both sides.*

CUT ON THE OUTER BORDER

NOTICE TO HEALTH CARE PROVIDERS

I HAVE AN ADVANCE DIRECTIVE (Living Will).

My Name: _____

My Doctor's Name:_____

Doctor's Phone: _____

NOTICE TO HEALTH CARE PROVIDERS

ADVANCE DIRECTIVE COPIES ARE HELD BY:

Name: _____

Address:_____

_____

Phone Numbers:_____

_____

OTHER ADVANCE DIRECTIVE COPIES ARE HELD BY:

Name: _____

Phone Numbers: _____

_____

Name: _____

Phone Numbers: _____

_____

I ALSO HAVE A HEALTH CARE AGENT.

Agent's Name: _____

Phone Numbers:_____

_____

My agent also has a copy of my health care power of attorney, and can make medical decisions for me if I am unable to do so.

FOLD HERE 1ST

FOLD HERE 2ND