LIVING WILL
and
DURABLE POWER OF ATTORNEY FOR HEALTH-CARE
FORMS
and
INSTRUCTIONS

The **Designation of Durable Power of Attorney for Healthcare** and **Living Will** are legal documents you may complete to help ensure that your wishes are carried out when you are unable to speak for yourself. **It is very important that your wishes expressed in these documents be discussed with your physician and family/ significant other.**

You may at sometime lose the ability to make sound judgements concerning medical treatment for reasons that may range from confusion caused by medication to coma following a major accident. When you cannot make decisions about your medical care, others, such as family members and physicians will need to take responsibility for these decisions. Often, it is difficult for them to know what your wishes are. The decision process in these complex situations is made easier when you have previously expressed wishes about your medical care, including the withholding and/or withdrawal of life prolonging procedures.

You must be an adult (age 18 or older) and of sound mind when completing these forms. **In order for these documents to be valid, they must be signed by you in the presence of two witnesses. Only one witness may be your spouse or relative.** The person you designate as your Durable Power for Healthcare **cannot** be a witness. These documents do **not** need to be notarized.

The **Durable Power of Attorney for Healthcare** document allows you to appoint another person to make healthcare decisions on your behalf when you are unable to do so. It is recommended that you appoint an adult who knows your wishes and will carry them out. It is suggested that you choose a person who has exhibited special care and concern for you and has maintained regular contact and is familiar with your personal, religious, moral and cultural beliefs. Your Durable Power of Attorney for Healthcare will have the authority to make all medical decisions on your behalf according to your wishes, including but not limited to the withholding / withdrawal of life prolonging procedures.

The **Living Will** document lets your physician(s) and others know your choices regarding the use of life prolonging procedures if you are unable to make decisions for yourself. Your physician and your Durable Power of Attorney for Healthcare are to follow the directives of the Living Will. Your physician is required to make a reasonable effort to transfer your care to another physician if he/ she is unable or unwilling to carry out your wishes specified in the Living Will.

These documents are valid as long as you do not rescind them or declare them void. These documents will continue indefinitely unless you provide for an expiration date. These documents will become void at time of death. If you decide at any time to revoke any portion of these documents, **immediately tell** this to your attending/treating physician. Also, retrieve and destroy all copies given to others and complete a new document(s).

You should keep the original completed documents. Copies should be given to:

- individual designated as Durable Power of Attorney for Healthcare
- family member(s), friends, as appropriate
- family physician or primary health care provider
- the hospital each time your are admitted
- nursing home or assisted living facility if this is your home
- clergy, and/or attorney (optional)

The Durable Power of Attorney for Healthcare, Living Will and these instructions are based on Florida law. These instructions are intended to be general guidelines only. If further guidance is needed or questions arise regarding these documents, your physician, clergy, or attorney should be contacted.

Note: If you are a Florida Hospital inpatient, you may receive additional information by watching the hospital's educational TV channel at 11 am and 7 pm. If you would like assistance after reviewing the information, please ask your nurse to contact the Chaplain, Case Management, or a Patient Relations Representative.

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PLEASE COMPLETE ALL FIELDS

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(DESIGNATION OF HEALTH CARE SURROGATE)

In the event that I, Name________________________________ Age_________ have been determined by my physician(s) to be incompetent/incapacitated (lack the ability) to provide informed consent for medical treatment and surgical and diagnostic procedures including but not limited to the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate as my decision maker (surrogate) to make health care decisions:

Name: __________________________________ / _______________________ Phone# (w) ____________________________
relationship (h) ____________________________
Address:____

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

Name: __________________________________ / _______________________ Phone# (w) ____________________________
relationship (h) ____________________________
Address:____

I fully understand that this designation will permit my decisionmaker to make all health care decisions on my behalf until I regain the ability to make health care decisions. The healthcare decisions may also include if necessary, the decisions to withhold, withdraw, or continue life prolonging procedures. My decisionmaker may also authorize my admission to or transfer from a health care facility and also apply for public assistance on my behalf. This designation is to remain in effect during any incapacity or incompetency I may experience.

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.

Witness: ____ Signature: ______________________________________

Witness: ____ Date: ____

LIVING WILL

I, willfully and voluntarily make known my desire that my dying **not** be prolonged under the following circumstances. If at any time I have a terminal condition and/or am in a persistent vegetative state, and if my attending/treating physician and a consulting physician have determined that there is no medical probability of my recovery from such condition(s), 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. I request to be permitted to die naturally with only the administration of medication or the performance of medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I also desire to have life prolonging procedures withheld/withdrawn when: (optional)

_______ Due to a debilitating disease condition in which I have no reasonable probability of recovering, I cannot communicate or interact purposely with others.
Initial

_______ Specify other condition: ____
Initial

In addition, I do ____ or I do not ____ want to be given nutrition (food) and/or hydration (water) artificially by a feeding tube or by intravenous feedings when it would serve only to prolong artificially the process of dying.
Initial Initial

Additional instructions (optional):____

I request that my Living Will be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

If I am pregnant and this is known to my physician(s), this Living Will shall have no force or effect during the course of my pregnancy.

I understand the full meaning of this Living Will, and I am emotionally and mentally competent to make these declarations.

Witness: ____ Signature: ______________________________________

Witness: ____ Date: ____