DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(DESIGNATION OF HEALTH CARE SURROGATE)
In the event that I, Rose Smith, age 74, 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: Theresa Gill / Relationship: daughter / Phone # (w) 555-111-2222 (h) 555-333-4444
Address: 88 Eagle Terrace, Tampa, FL 33334

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

Name: Maria Brady / Relationship: daughter / Phone# (w) 555-555-7777 / (h) 555-888-9999
Address: 77 Dermott Lane, Tampa, FL 33444

I fully understand that this designation will permit my decision maker 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 decision maker may also authorize my admission to or transfer from a healthcare 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): N/A

I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility.

_____ _____
Signer Signature Date

_____
Printed Name

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no medical probability of my recovery from such condition(s), I direct that life prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.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 procedures deemed necessary to provide me with comfort care or to alleviate pain.

I also desire to have life prolonging procedures withheld/withdrawn when:

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)

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.

_____ _____

Signer Signature Date

_____

Printed Name

The following witnesses were present during the signing of the Durable Power of Attorney and Living Will and verbally stated aloud for the record that the signer is of sound mind.

Witness Name and Address: William Wallace 8878 Scotland Place, Wesley Chapel, FL 33566

Signature: _____

Date: _____

Witness Name and Address: Patricia Wallace 8878 Scotland Place, Wesley Chapel, Fl 335566

Signature: _____

Date: _____

State of Florida

County of _____

Sworn to (or affirmed) and subscribed before me by means of

☐ Physical Presence
OR
☐ Online Notarization

this ____ day of _____,
_____,

BY

_____,

and witnessed by
_____ and

_____

who are personally known to me

☐ OR

☐ have produced identification.

_____
Type of Identification

Notary Stamp Above

_____
Notary Public - State of Florida -
Signature

_____
Notary Public - State of Florida –

Printed Name