

LIVING WILL DECLARATION

I, _____ of _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

- A. If at any time I have a terminal condition, 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is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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. I specifically exonerate and hold my physicians harmless for any liability which may otherwise result from rendering such opinion.

A terminal condition, defined in Florida Statute 765.101 (17), is “a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.”

An end-stage condition, defined in Florida Statute 765.101 (4), is “an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and for which, to a reasonable degree of medical probability, treatment of the irreversible condition would be ineffective.”

A persistent vegetative state, defined in Florida Statute 765.101 (12 a, b), is “a permanent and irreversible condition of unconsciousness in which there is: (a) the absence of voluntary action or cognitive behavior of any kind, (b) an inability to communicate or interact purposefully with the environment.”

If I am in any terminal condition, end-stage condition, or persistent vegetative state, it is my intent to fully withhold or withdraw life-prolonging procedures including but not limited to:

- Electrical, mechanical or chemical resuscitation of my heart when it has stopped beating.
- Nasogastric tube feeding, or any other form of artificial hydration or nutrition, when I am paralyzed or unable to take nourishment or hydration by mouth.
- Mechanical respiration when I am no longer able to sustain my own breathing.
- Such other procedures that would have the effect of prolonging life.

- B. In the event my attending physician concludes that I lack the capacity to make health care decisions for myself or provide informed consent, and another physician agrees that I lack such capacity, then I designate, as my surrogate to carry out the provisions of this declaration:

Name: _____

Address: _____

OR

Name: _____

Address: _____

to carry out the provisions of this declaration. I have discussed my wishes concerning my medical care and my views regarding life-prolonging procedures with my surrogates. I may further document my desires regarding specific situations in which I would want treatment performed or withheld, for the use of my surrogate in making any health care decisions for me.

- C. If a surrogate or proxy cannot be found from any of the persons listed in the preceding paragraph, the health care facility may proceed as directed by me in this my Living Will.
- D. Before proceeding in accordance with this my Living Will, my surrogate must be satisfied that:
 - 1. I do not have a reasonable probability of recovering competency so that such right could be exercised directly by me; and
 - 2. my physical condition is terminal, end-stage, or I am in a persistent vegetative state; and
 - 3. any limitations or conditions or additional criteria set forth herein have been carefully considered and satisfied.
- E. If a Court Order is necessary to carry out my wishes stated herein, I specifically direct immediate action to obtain the necessary Order and said Order be presented, without delay, to the appropriate medical facility and staff to implement my instructions stated herein.
- F. 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.
- G. In the absence of the original of this Declaration, I authorize that any person may act and rely upon a copy of this absent any expression by me of revocation. This Declaration is made in accordance with and intended to be valid in all respects under Florida Constitution and Statutes, and in accordance with my privacy rights under the Florida Constitution and U. S. Constitution, and shall be valid in any place, country or jurisdiction in which the application of this Declaration becomes necessary.
- H. In addition to the other powers granted by this document, my surrogate shall have the power and authority to serve as my personal representative for all purposes of the Health

Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), 45 CFR Section 160 through 164.

___ Yes ___ No. At the time of my death, should my attending physician determine that any part or organ of my body might be of use in preserving the life or quality of life of another person, I authorize and direct my physician to utilize such part or organ of my body for such purpose as will accomplish these ends.

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

Executed _____

Sign _____

Address _____

The undersigned hereby attest to their belief that the principal, _____ was of sound mind when the principal signed this Living Will Declaration. We further attest that at least one of us is not the principal's spouse or blood relative.

Witness _____

Witness _____

Address _____

Address _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me on _____, by _____, who is personally known to me or who has produced _____ as identification.

NOTARY PUBLIC:

NOTARY SEAL:

Sign _____

Print _____

My Commission Expires _____

Commission Number _____