DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process" Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive For Florida Residents

Standard State Statutory Advance Directive for Health Care Choices

Statutory Advance Directive
For Florida Residents

_____ _____
Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The Florida state legislature has designed a combined Power of Attorney for Health Care and Living Will (health care instruction) for use by the public. As this document was designed by your state government, it is in full compliance with all applicable statutes and laws.

There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your Advance Directive is fully and properly filled out.

By completing your Lifecare Directive, you can have the peace of mind that some of your wishes are known and can be followed. It is also a meaningful gift to those you love. Your completed directive will help ensure that you r loved ones will have to make fewer difficult choices for you without having an understanding of what you would want done.

***Understanding Your Directive*:**

This directive is written in three parts. While it is best if you fill out the entire document, you may choose to complete only ***Section I***, which is a living will, through which you may leave a statement of your wishes. Or, you may choose to complete only ***Section II***, which is a declaration of your desires to be an organ and tissue donor. Or you may complete only ***Section III***, which is a Health Care Surrogate designation by which to name someone to speak for you if you ever become unable to speak for yourself.

Ideally, you will complete all three sections to ensure that your wishes are known and that you are represented as fully as possible.

SECTION I:

FLORIDA LIVING WILL

DECLARATION

(*Pursuant to Florida Statute §765.303*)

Declaration made this _____ day of _____, 20_____,

Be it Known that 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 (*initial as applicable*):

___☐___ I have a terminal condition
___☐___ I have an end-stage condition
___☐___ 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. I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (*optional*): _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature:

Full Name: _____

Signed: _____

Date: _____

Required Witnesses:
(*at least one of the witnesses must not be a spouse or blood relative*)

1. Signature: _____

   Printed Name: _____

   Address: _____

2. Signature: _____

   Printed Name: _____

   Address: _____

SECTION II:

ANATOMICAL GIFT

DECLARATION

(*Pursuant to Florida Statute §765.514*)

Full Name: _____

Be it Known that I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires (*initial as applicable*):

_____ Any needed organs or parts for the purpose of transplantation, therapy, medical research, or education.

_____ Only the following organs or parts:
Specify: _____

_____ My entire body for anatomical study, if needed (*requires prior arrangements with a medical school, university, or other approved institution*)

Limitations, Special Wishes, Other Concerns: _____
_____
_____
_____

Donor Signature: _____

Required Witnesses:
(*at least one of the witnesses must not be a spouse or blood relative*)

1. Signature: _____

   Printed Name: _____

   Address: _____

2. Signature: _____

   Printed Name: _____

   Address: _____

SECTION III:

DESIGNATION OF HEALTH CARE SURROGATE

(*Pursuant to Florida Statue §765.203*)

Full Name:_____

Be It Known That:

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:

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

Alternate: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law (above), 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 transfer 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: _____

Signature:

Full Name: _____

Signed: _____

Date: _____

Required Witnesses:
(*at least one of the witnesses must not be a spouse or blood relative*)

1. Signature: _____

   Printed Name: _____

   Address: _____

2. Signature: _____

   Printed Name: _____

   Address: _____