

**No Signature Required.
For Reference Only.**

An Advanced Directive for Florida
A Practical Form for All Adults

A **Florida advance directive** is a set of declarations given to medical professionals on behalf of a patient who may be unable to make decisions about their treatment during the time of care. The State of Florida recognizes a Living Will Declaration, outlining a patient's wishes, and a Designation of Health Care Surrogate, which appoints a third party to make health care decisions on behalf of the patient.

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form complies with Florida State Statutes (in FS § 765.201-765.309).

Definitions:

Advanced Directive § 765.101(1) – “Advanced directive” means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of this chapter.

Health care § 765.101(5) – “Health care” means care, services, or supplies related to the health of an individual and includes, but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the individual's physical or mental condition or functional status or that affect the structure or function of the individual's body.

Health care decision § 765.101(6) – “Health care decision” means:

- (a) Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures and mental health treatment, unless otherwise stated in the advance directives.
- (b) The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.
- (c) The right of access to health information of the principal is reasonably necessary for a health care surrogate or proxy to make decisions involving health care and to apply for benefits.
- (d) The decision to make an anatomical gift pursuant to part V of this chapter.

Living Will (§ 765.101(13)) – “Living will” or “declaration” means:

- (a) A witnessed document in writing, voluntarily executed by the principal in accordance with

s. 765.302; or

- (b) A witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.

Minor's principal (§ 765.101(14)) – “Minor's principal” means a principal who is a natural guardian as defined in s. 744.301(1); legal custodian; or, subject to chapter 744, legal guardian of the person of a minor.

Surrogate (§ 765.101(21)) – “Surrogate” means any competent adult expressly designated by a principal to make health care decisions and to receive health information. The principal may stipulate whether the authority of the surrogate to make health care decisions or to receive health information is exercisable immediately without the necessity for a determination of incapacity or only upon the principal's incapacity as provided in s. 765.204.

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LIVING WILL

Declaration made this ____ day of _____, 20____, 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) I have a terminal condition, or

_____(initial) I have an end stage condition, or

_____(initial) I am in a persistent vegetative state, and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such a 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: _____ Phone: _____

Address: _____

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

Additional Instructions (optional):

(Signed) _____

Witness Signatures:

Witness: _____ Witness: _____

Printed Name: _____ Printed Name: _____

Address: _____ Address: _____

Phone Number: _____ Phone Number: _____

At least one witness must not be a spouse or a blood relative of the principal.

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Designation of Health Care Surrogate for Minor

I/We, _____, the

parent(s)/natural guardian(s) as defined in s. 744.301(1), Florida Statutes;

legal custodian(s);

legal guardian(s) of the following minor(s):

pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) if I/we am/are not able or reasonably unavailable to provide consent for medical treatment and surgical and diagnostic procedures:

Name: _____

Address: _____

Phone: _____

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

Name: _____

Address: _____

Phone: _____

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name: _____

Name: _____

Signed: _____ Date: _____

WITNESSES:

1. Name: _____ Date: _____

2. Name: _____ Date: _____