Living Will Instructions and Explanations

In Florida, every competent adult has the right to make decisions pertaining to his or her own health, including the right to choose or refuse medical treatment. To ensure this right is not lost due to physical or mental incapacity, the Florida legislature allows a person to plan for incapacity and, if desired, designate another person to act on his or her behalf in the event of incapacity. A Living Will directs the provision, withholding, or withdrawal of life prolonging procedures in the event of certain conditions. Unlike a legal will (or Last Will and Testament), a Living Will does not dispose of property on or after an individual's death.

When using the following form in completing your living will, follow the instructions carefully. In Section One, include either Option (1), which indicates that you wish to NOT have life-prolonging medical procedures in the circumstances outlined, or Option (2), which indicates that you wish to have your life preserved as long as reasonably possible. In Section Two, choose whether or not you wish to have medications or procedures to alleviate pain or discomfort. Section Three is optional. Should you choose, you may designate an individual to act as your Health Care Surrogate, providing consent and making medical decisions in the event of your incapacity. This section need not be included if you do not wish to designate a surrogate.

Your Living Will must be signed in the presence of two witnesses. At least one witness must be neither your spouse nor your blood relative. If you are unable to sign your Living Will, one of your witnesses may do so for you in your presence and with your instruction. If you are designating a Health Care Surrogate, that individual may not be a witness to this document. After you complete your Living Will, a signed copy should be provided to your physician and hospital.

Your Living Will may be revoked at any time by a signed and dated revocation letter, by physically destroying the original document, or by executing a new living will which is materially different from this document.

LIVING WILL

Declaration made this _____ day of _____, 20____ . I, _____, willfully and voluntarily make known my desire

Section One – Treatment Wishes (include only one)

Option (1) that if I am incapacitated and my quality of life becomes unacceptable to me, and 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.

A quality of life that is unacceptable to me means (include any that apply):

(a) I am unconscious (chronic coma or persistent vegetative state)
(b) I am unable to communicate my needs in any way
(c) I am unable to recognize family or friends
(d) I have a terminal condition
(e) I am totally dependent on others for care
(f) Other: (describe)

Include only one:

(a) Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).
(b) If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

In addition, I do not want the following treatments under any circumstances (include any that apply):

(a) Cardiopulmonary Resuscitation (CPR)
(b) Ventilation (breathing machine)
(c) Feeding tube
(d) Dialysis
(e) Other(s): (describe)

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.

Option (2) that I want my life prolonged as long as possible within acceptable medical practice and standards.

Section Two – Relief of Pain (include only one)

(a) I wish to have the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

(b) I do NOT wish to have any administration of medication or the performance of any medical procedure to provide me with comfort care or to alleviate pain.

Section Three - Health Care Surrogate (optional)

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:
First Name: _____Last Name: _____
Address_____City: _____
State:_____ Phone: (_____) _____ - _____

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

Additional Instructions (optional): _____
_____
_____
_____

Signed: _____ Date: _____

Declaration of Witnesses
As witnesses we declare that the above named person is personally known to us, appears to be of sound mind and signed this directive willingly and free of undue influence or duress. We are legal adults. We declare that he / she signed this will in our presence as we signed as witnesses in the presence of each other, all being present at the same time. Under penalty of perjury we declare these statements to be true and correct on this _____ day of _____ 20____.

Signature _____ Signature _____

Address _____ Address _____
_____ _____
_____ _____

Phone _____ Phone _____