LONG TERM
CARE SOLUTIONS, LLC

DESIGNATION OF HEALTH CARE SURROGATE
(Florida Statutes 765-203)

Name:

_____

(Last) (First) (Middle Initial)

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:

Name: _____

Address: _____

_____

Zip Code: _____ Phone: _____

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

Name: _____

Address: _____

_____

Zip Code: _____ Phone: _____

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, 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:

_____

Signed:

_____

Date: _____

WITNESSES:

Signature: _____
Printed Name: _____
Address: _____

Signature: _____
Printed Name: _____
Address: _____

LONG TERM
CARE SOLUTIONS, LLC

LIVING WILL
(Florida Statues 765-303)

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 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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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. 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: _____

Address: _____

Zip Code: _____ Phone: _____

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

Additional instructions (optional):

_____

_____

_____

Name: _____

Signature: _____

WITNESSES:

Signature: _____

Printed Name: _____

Address: _____

Signature: _____

Printed Name: _____

Address: _____