

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

Name: Sally A. Smith

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: Henry P. Smith

Address: 100 Fifth Avenue
Miami, Florida

Phone: 212-005-8765

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

Name: Susan Smith Brown

Address: 333 8th Avenue
New York, New York

Phone: 212-335-8675

I fully understand that this designation will permit my designee to make health care decisions 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: Dr. Walter Brown
Address: Miami, Florida

Name: Henry P. Smith
Address: _____

Sally A. Smith

Date: November _____, 2000

Witness

Address

Witness

Address

FLORIDA LIVING WILL

Declaration made this November _____, 2000, I, Sally A. Smith, 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 both mentally and physically incapacitated

- and I have a terminal condition, or
- and I have an end-stage condition, or
- and 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medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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: Henry P. Smith
Address: 100 Fifth Avenue
Miami, Florida
Phone: 212-005-8765

I wish to designate the following person as my alternate surrogate, to carry out the provisions of this declaration should my surrogate be unwilling or unable to act on my behalf:

Name: Susan Smith Brown
Address: 333 8th Avenue
New York, New York
Phone: 212-335-8675

Additional Instructions (optional):

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

Sally A. Smith

Residence:
Street: 100 Fifth Avenue
City: Miami
State: Florida

Witness

Address

Witness

Address