INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

ADD PERSONAL INSTRUCTIONS (IF ANY)

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

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 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):

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FLORIDA DESIGNATION OF HEALTH CARE SURROGATE (CONTINUED)

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:

PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT

Name: _____

Address: _____

Name: _____

Address: _____

SIGN AND DATE THE DOCUMENT

Signed: _____

Date:_____

WITNESSING PROCEDURE

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: _____

Address: _____

Witness 2:

Signed: _____

Address: _____

Courtesy of **Partnership for Caring, Inc** 6/00
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455