FLORIDA LIVING WILL

Declaration made this ______________ day of _____________, _______
(day) (month) (year)

I, _______________________________________________________,
willfully and voluntarily make known my desire that my dying not be
automatically prolonged under the circumstances set forth below, and I do
hereby declare that:

If at any time I am incapacitated and

__________I have a terminal condition, or

__________I have an end-stage condition, or

__________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withheld or withdrawn when the application of such procedures would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: _____________________________________________

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FLORIDA LIVING WILL (CONTINUED)

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: _____________________________________________________

Address: ___________________________________________________

_________________________________  Zip Code: _____________

Phone: _______________________________

Additional Instructions (optional):

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

Signed: ____________________________________________________

Witness 1::

Signed: _______________________________

Address: _____________________________________________

Witness 2:

Signed: _______________________________

Address: _____________________________________________

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Courtesy of Partnership for Caring, Inc  6/00
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