FLORIDA
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Florida Advance Directive

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete Part One, Part Two, or both, depending on your advance planning needs. You must complete Part Three.

Part One. The **Florida Designation of Health Care Surrogate** lets you name a competent adult to make decisions about your medical care, including decisions about life-prolonging procedures, if you can no longer speak for yourself. The designation of health care surrogate is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your health care surrogate's powers go into effect when your doctor determines that you are physically or mentally unable to communicate a willful and knowing health care decision.

Part Two. The **Florida Living Will** lets you state your wishes about health care in the event that you are in a persistent vegetative state, have an end-stage condition or develop a terminal condition. Your living will goes into effect when your physician determines that you have one of these conditions and can no longer make your own health care decisions.

Your living will also allows you to express your organ donation wishes.

Part Three contains the signature and witness provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs. However, unless your Designation of Health Care Surrogate expressly states otherwise, your health care surrogate presumptively may make health care decisions regarding mental health treatment.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Completing Your Florida Advance Directive

Whom should I appoint as my surrogate?

Your surrogate is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your surrogate may be a family member or a close friend whom you trust to make serious decisions. The person you name as your surrogate should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate surrogate. The alternate will step in if the first person you name as a surrogate is unable, unwilling, or unavailable to act for you.

How do I make my Florida Advance Directive legal?

The law requires that you sign your Advance Directive in the presence of two adult witnesses, who must also sign the document. If you are physically unable to sign, you may have someone sign for you in your presence and at your direction and in the presence of your two witnesses.

Your surrogate and alternate surrogate cannot act as witnesses to this document. At least one of your witnesses must not be your spouse or a blood relative.

Note: You do not need to notarize your Florida Advance Directive.

Should I add personal instructions to my Florida Advance Directive?

One of the strongest reasons for naming a surrogate is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your surrogate carry out your wishes, but be careful that you do not unintentionally restrict your surrogate's power to act in your best interest. In any event, be sure to talk with your surrogate about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You can always revoke your *Florida Advance Directive*. State law permits you to revoke your document in the following ways:

1. through a signed and dated writing showing your intent to revoke;
2. by physically destroying the original, or having someone destroy it for you in your presence at your direction;
3. by orally expressing your intent to revoke; or
4. by executing a new Advance Directive that supersedes the older document.

You should notify your health care provider and surrogate(s) to ensure that your revocation is effective.

If you name your spouse as your surrogate and you are divorced or your marriage is subsequently annulled, your spouse's powers as surrogate will be automatically revoked. If you would like your spouse's powers to continue in the event of a divorce or annulment, you can state this in the "Additional Instructions" section on page 2 of the form by adding an instruction such as, "The authority of my surrogate shall not be revoked by divorce or annulment of our marriage."

What other facts should I know?

If you would like to give your surrogate the authority to refuse life-prolonging treatment for you in the event that you become terminally ill and incompetent while you are pregnant, you must add an instruction such as, "My surrogate has the authority to order the withholding or withdrawal of life-prolonging treatment, even if I am pregnant," under the "Additional Instructions" section on page 2 of the form.

Also, unless you expressly state otherwise under the "Additional Instructions" section, your health care surrogate, if you appoint one, does not have authority to authorize abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments, or voluntary admission to a mental health facility.

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

Part One. 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 under s. 765.202 Florida Statutes:

Name: _____

Address:_____

_____ Zip Code: _____

Phone: _____

If my surrogate is not willing, able or reasonably available 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.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are

INSTRUCTIONS

Part One. Designation of Health Care Surrogate

in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(Initial the following that apply):

I authorize my health care surrogate to:

INITIAL NEXT TO THE STATEMENTS THAT APPLY

_____ Receive any of my health information, whether oral or recorded in any form or medium that:

1. Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

INITIAL NEXT TO THE STATEMENTS THAT APPLY

_____ Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

While I have decision-making capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation. To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

Part One. Designation of Health Care Surrogate

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES. PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY: (1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION; (2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION; (3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION; OR (4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.
MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

INITIAL HERE IF YOU WANT YOUR SURROGATE'S AUTHORITY TO START NOW. THESE ARE OPTIONAL.

IF I INITIAL THIS BOX [_____], MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

IF I INITIAL THIS BOX [_____], MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERCEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Additional instructions and restrictions (optional):

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

INITIAL EACH THAT APPLIES

Part Two. Declaration

Declaration made this _____ day of _____, _____,
(day) (month) (year)

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 all that apply)

_____ 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.

My failure to designate a health care surrogate in Part One shall not invalidate this declaration.

ORGAN DONATION (OPTIONAL)

INITIAL ONLY ONE OF THE FOUR OPTIONS

IF YOU HAVE ALREADY ARRANGED TO DONATE YOUR ORGANS TO A SPECIFIC DONEE, INITIAL THIS OPTION, AND INDICATE THE DETAILS OF YOUR ARRANGEMENT HERE

ORGAN DONATION (OPTIONAL)

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (initial one choice below):

_____ any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;

_____ only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education:

_____

_____

_____

_____ my body for anatomical study if needed. Limitations or special wishes, if any:

_____

_____

_____

_____ I have already arranged to donate

_____ Any needed organs, tissues, or eyes,

_____ The following organs, tissues, or eyes:

_____

_____

_____

to the following donee:_____

Phone:_____

Address:_____

_____ Zip Code:_____

Part Three. Execution

PRINT YOUR NAME

I, _____
understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

SIGN AND DATE THE COCUMENT

Signed: _____

Date: _____

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: _____

Address: _____

_____

Witness 2:

Signed: _____

Address: _____

_____

OPTIONAL

(Optional) 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:

_____

_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Florida Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your surrogate and alternate surrogate, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your surrogate(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Florida document.

7. Be aware that your Florida document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advanced directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

- ☐ $23 helps us provide free advanced directives
- ☐ $47 helps us maintain our free HelpLine
- ☐ $64 helps us provide webinars to hospice professionals

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

AD_2015

GuideStar Exchange GOLD PARTICIPANT

OR donate online today: www.caringinfo.org/donate