

DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, “the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a ‘scientific’ process” Because of “political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective” (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that “The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow,” and suggesting that revised and enhanced documents “may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes” (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic professionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or “health care instruction” or “declaration”) and medical power of attorney (or “proxy”) forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, “*Should I Use a Shorter Standard Directive?*” available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~



Statutory
Advance Directive
For
Florida Residents



Standard State Statutory
Advance Directive for
Health Care Choices

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Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warranted to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Florida Residents

Print Full Name

Date of Birth

Your right (when age 18 or older): To Document Your Personal Wishes,
and to have these wishes followed ~~

The Florida state legislature has designed a combined Power of Attorney for Health Care and Living Will (health care instruction) for use by the public. As this document was designed by your state government, it is in full compliance with all applicable statutes and laws.

There is an introduction that summarizes the scope and purpose of the document, as well as providing directions for its completion. Read it carefully to ensure that your Advance Directive is fully and properly filled out.

By completing your Lifecare Directive, you can have the peace of mind that some of your wishes are known and can be followed. It is also a meaningful gift to those you love. Your completed directive will help ensure that you r loved ones will have to make fewer difficult choices for you without having an understanding of what you would want done.

Understanding Your Directive:

This directive is written in three parts. While it is best if you fill out the entire document, you may choose to complete only **Section I**, which is a living will, through which you may leave a statement of your wishes. Or, you may choose to complete only **Section II**, which is a declaration of your desires to be an organ and tissue donor. Or you may complete only **Section III**, which is a Health Care Surrogate designation by which to name someone to speak for you if you ever become unable to speak for yourself.

Ideally, you will complete all three sections to ensure that your wishes are known and that you are represented as fully as possible.

Signature:

Full Name: _____

Signed: _____

Date: _____

Required Witnesses:

(at least one of the witnesses must not be a spouse or blood relative)

1. Signature: _____

Printed Name: _____

Address: _____

2. Signature: _____

Printed Name: _____

Address: _____

SECTION II:
ANATOMICAL GIFT
DECLARATION

(Pursuant to Florida Statute §765.514)

Full Name: _____

Be it Known that I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires (*initial as applicable*):

_____ Any needed organs or parts for the purpose of transplantation, therapy, medical research, or education.

_____ Only the following organs or parts:
Specify: _____

_____ My entire body for anatomical study, if needed (*requires prior arrangements with a medical school, university, or other approved institution*)

Limitations, Special Wishes, Other Concerns: _____

Donor Signature: _____

Required Witnesses:

(at least one of the witnesses must not be a spouse or blood relative)

1. Signature: _____

Printed Name: _____

Address: _____

2. Signature: _____

Printed Name: _____

Address: _____

SECTION III:
DESIGNATION OF HEALTH CARE
SURROGATE

(Pursuant to Florida Statute §765.203)

Full Name: _____

Be It Known That:

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:

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

Alternate: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

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 (above), 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: _____

Address: _____

Name: _____

Address: _____

Signature:

Full Name: _____

Signed: _____

Date: _____

Required Witnesses:

(at least one of the witnesses must not be a spouse or blood relative)

1. Signature: _____

Printed Name: _____

Address: _____

2. Signature: _____

Printed Name: _____

Address: _____