LIVING WILL

I, _____, want to choose how I will be treated by my healthcare
PRINT NAME
providers. If I am unable to communicate or make my healthcare decisions because of illness or injury, I want my healthcare providers, **healthcare surrogate** (**HCS**) and loved ones to follow this living will.

In the event that I am unable to communicate or make my medical decisions, my HCS may:

- Talk to my healthcare providers and have access to my medical information
- Authorize my treatment or have it withdrawn based on my choices
- Authorize transportation to another facility
- Make decisions regarding organ/tissue donation based on my choices
- Apply for public benefits, such as Medicare/Medicaid, on my behalf

INDICATE YOUR MEDICAL CHOICES

I understand that this living will only becomes effective when I am:

1. No longer able to communicate or when I am not capable of making my healthcare decisions known **AND**
2. Two physicians have determined that I have one of the following:
   - ⇒ A terminal or end-stage condition and there is little or no chance of recovery
   - ⇒ A condition of permanent and irreversible unconsciousness, such as a coma or vegetative state
   - ⇒ An irreversible and severe mental or physical illness, such as end-stage dementia, that prevents me from communicating with others, recognizing my loved ones or caring for myself in any way

If I develop one of these conditions, I want my healthcare providers and my HCS to follow the choices I have made in this living will.

My specific choices if I have one of the above conditions	Circle Your Choice	
Cardio-pulmonary resuscitation (CPR) if my heart and breathing stops	Yes I Want	No I Do Not Want
A breathing machine (ventilator) if I am unable to breathe on my own	Yes I Want	No I Do Not Want
Nutrition and fluids through tubes in my veins, nose or stomach	Yes I Want	No I Do Not Want
Kidney dialysis, a pacemaker or a defibrillator, or other such machines	Yes I Want	No I Do Not Want
Surgery or admission to a hospital Intensive Care Unit	Yes I Want	No I Do Not Want
Medications that can prolong my dying, such as antibiotics	Yes I Want	No I Do Not Want

MAKE IT LEGAL

I fully understand the meaning of this Living Will. I am emotionally and mentally capable of signing this document. This document reflects my personal choices regarding medical care.

_____ _____ _____

Signature Printed name Date

Witness 1: _____ _____

Print name Signature

Address: _____

Witness 2: _____ _____

Print name Signature

Address: _____

**** Your healthcare surrogate(s) cannot serve as a witness to this living will.***
At least one witness must be someone other than your spouse or a blood relative.

Next Steps

- ☐ Discuss your living will with your healthcare provider(s).
- ☐ Communicate your choices to your HCS and alternate surrogate.
- ☐ Once your living will has been signed and witnessed, give copies to: your doctor(s), your HCS and alternate surrogate and your loved ones.
- ☐ Keep your original copy where it can be easily found.
- ☐ Review your living will on a regular basis. A living will can be changed at any time.

Copies of this document have been given to:_____

_____

_____

*The state of Florida does **NOT** require notarization of living wills, however some states do. Please check your state's requirements. This space is being provided for those individuals who need notarization.*

Signature: _____County of: _____

The foregoing instrument was acknowledged before me on _____ (date).

By: _____Signature of Notary: _____

Seal of Notary:

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