

**INSTRUCTIONS**

**PRINT THE  
DATE**

**PRINT YOUR  
NAME**

**PLEASE INITIAL  
EACH THAT  
APPLIES**

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

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PARTNERSHIP  
FOR CARING,  
INC.**

**FLORIDA LIVING WILL**

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  
\_\_\_\_\_ 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withheld or withdrawn when the application of such procedures would  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: \_\_\_\_\_

**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: \_\_\_\_\_

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

**ADD  
PERSONAL  
INSTRUCTIONS  
(IF ANY)**

**SIGN THE  
DOCUMENT**

**WITNESSING  
PROCEDURE**

**TWO  
WITNESSES  
MUST SIGN  
AND PRINT  
THEIR  
ADDRESSES**

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PARTNERSHIP  
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*Courtesy of Partnership for Caring, Inc* 6/00  
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