Florida Living Will Declaration

I, (Print name)_____(Date of Birth) ___/___/___ am emotionally and mentally competent to complete this document willfully and voluntarily. It is my wish that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if I am incapacitated and

_____ (Initial Here) **I have a terminal condition** (A condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and, without treatment, it can be expected to cause death.)

OR

_____ (Initial Here) **I have an end-stage condition** (An irreversible condition caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration and treatment of the condition would be ineffective.)

OR

_____ (Initial Here) **I am in a persistent vegetative state** (A permanent and irreversible condition of unconsciousness in which there is the absence of voluntary action or cognitive behavior and an inability to communicate or interact purposefully with the environment.)

and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct that life-prolonging procedures be withheld or withdrawn when such procedures would only serve to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medications or procedures deemed necessary to provide me with comfort 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 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 my wishes as declared here:

Name: _____ **Phone:** _____

Address: _____

Additional Instructions (optional):_____

_____

PATIENT'S SIGNATURE: _____ **Date:** _____/_____/20_____

Print Name: _____ **Address:** _____

SIGNATURES OF WITNESSES:

First witness:

Print Name: _____

Address: _____

Signature: _____

Date: _____/_____/ 20_____

Second witness:

Print Name: _____

Address: _____

Signature: _____

Date: _____/_____/ 20_____

[18 years or older and not named as a surrogate. At least one of the witnesses must not be related by blood nor be the patient's spouse.]

My Wishes at End of Life (Living Will)

A Living Will document is a statement about your wishes concerning life-prolonging procedures at the end of your life.

- It is a good idea to give copies to your health care surrogate(s) and/or physicians.
- Please discuss your health care wishes with whomever you name as your surrogate(s)
- You may revoke (destroy or cancel) an advance directive at any time.

Instructions: This will be your legal Living Will document once it is:

[ ] filled out,

[ ] signed by you,

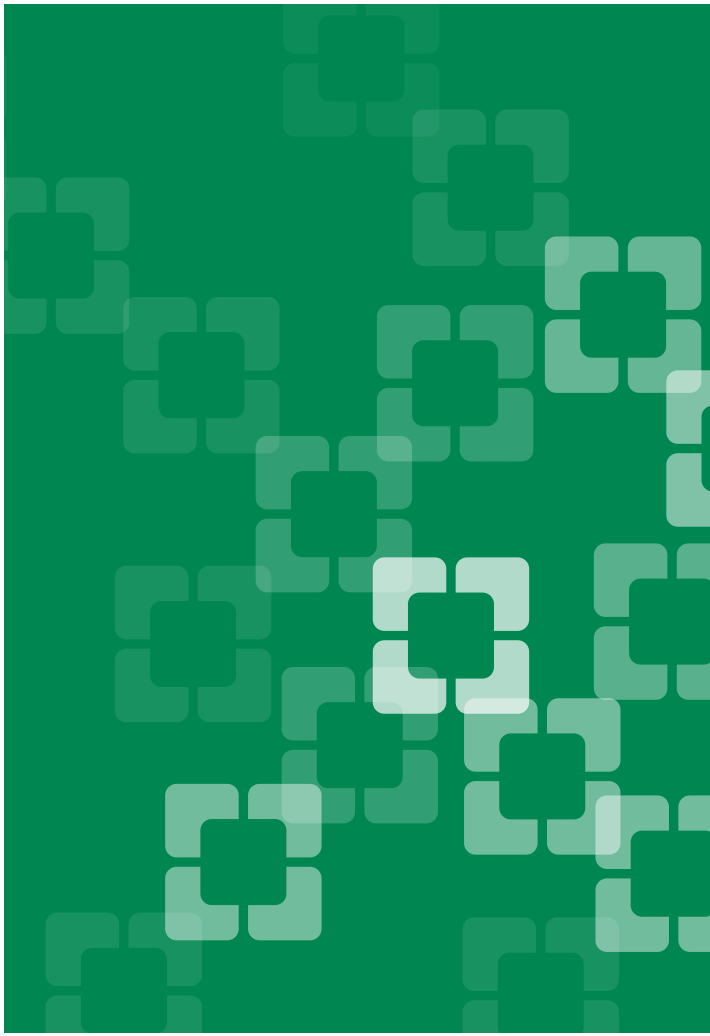
[ ] dated,

[ ] and witnessed by two people 18 years or older and not named as a surrogate. At least one of the witnesses must not be related by blood nor be the patient's spouse.

Cleveland Clinic
Indian River Hospital

V1.10.2020

My Wishes at End of Life (Living Will)



Cleveland Clinic
Indian River Hospital