Florida Designation of Health Care Surrogate

[PRINT YOU NAME]

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:

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

Name: ...

Address: ...

... Zip Code: _______

Phone: ...

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

[PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATIVE 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.

[ADD PERSONAL INSTRUCTIONS (IF ANY)]

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:

[PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT]

Name: ...

Address: ...

Name: ...

Address: ...

[SIGN AND DATE THE DOCUMENT]

Signed: ...

Date: ...

[TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES]

Witness #1:

Signed: ...

Address: ...

Witness #2:

Signed: ...

Address: ...