## LIVING WILL

## TO MY FAMILY, MY PHYSICIAN, MY LAWYER:

If the time comes when I can no longer take part in decisions for my own future, this statement and declaration shall stand as the expression of my wishes. I recognize that death is as much a reality as birth, growth, maturity, and old age — it is but a phase in the cycle of life and is the only certainty. I do not fear death as much as I fear the indignity of deterioration, dependence, and hopeless pain. If there is no reasonable expectation of my recovery from physical or mental disability, I wish to be allowed to die naturally and not be kept alive by artificial means or heroic measures, but wish only that drugs be mercifully administered to me for terminal suffering, even if they hasten the moment of my death.

I recognize that my wishes place a heavy burden of responsibility upon you, and I therefore make the following declaration with the intention of sharing this responsibility and this decision with you and of mitigating any feelings of guilt that you may have:

## **DECLARATION**

1,	, hereby revoke any and	all Declarations
[Print Name]		
previously made by me, and make this Declaration on		
	[Month and Day]	[Year]

I willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time:

- (a) I am incapacitated; and
- (b) (i) I have a terminal condition, or (ii) I have an end-stage condition, or (iii) I am in a persistent vegetative state, as those terms are defined by Florida Statutes Section 765.101 or any successor statute thereto; and
- (c) My primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition,

then I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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

designate as	my surrogate to	earry out the provision of this declaration:
Name:		
Address:		
Phone:	Home:	Cell:
If my surrog surrogate:	gate is unwilling	r unable to perform these duties, I wish to designate as my alternate
Name:		
Address:		
Phone:	Home:	Cell:
=	ate surrogate is unate surrogate:	willing or unable to perform these duties, I wish to designate as my
Name:		
Address:		
Phone:	Home:	Cell:
I understand make this D	-	f this Declaration, and I am emotionally and mentally competent to
		[Sign Here]
The declarate	nt is known to m	, and I believe declarant to be of sound mind.
Witness		
Witness		

regarding the withholding, withdrawal or continuation of life-prolonging procedures, I wish to

<sup>\*</sup>Please note that at least one of the witnesses must be someone other than a spouse or a blood relative.