FLORIDA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR FLORIDA ADVANCE DIRECTIVE

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part One. The **Florida Designation of Health Care Surrogate** lets you name a competent adult to make decisions about your medical care, including decisions about life-prolonging procedures, if you can no longer speak for yourself. The designation of health care surrogate is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part Two. The **Florida Living Will** lets you state your wishes about health care in the event that you are in a persistent vegetative state, have an end-stage condition or develop a terminal condition. Your living will also allows you to express your organ donation wishes.

Part Three contains the signature and witness provisions so that your document will be effective.

You may complete Part One, Part Two, or both, depending on your advance planning needs. **You must complete Part Three**.

How do I make my Florida Advance Directive legal?

The law requires that you sign your Advance Directive in the presence of two adult witnesses, who must also sign the document. If you are physically unable to sign, you may have someone sign for you in your presence and at your direction and in the presence of your two witnesses. Your surrogate and alternate surrogate cannot act as witnesses to this document. At least one of your witnesses must not be your spouse or a blood relative.

Note: You do not need to notarize your Florida Advance Directive.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You can appoint a second person as your alternate agent. An alternate agent will step in if the person you name as agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your health care surrogate's powers go into effect when your doctor determines that you are physically or mentally unable to communicate a willful and knowing health care decision.

Your living will goes into effect when your physician determines that you have one of these conditions and can no longer make your own health care decisions.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Unless you expressly state otherwise under the "Specific Instructions" section, your health care surrogate, if you appoint one, does not have authority to authorize abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments, or voluntary admission to a mental health facility.

Your agent will be bound by the current laws of Florida as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You can always revoke your Florida Advance Directive. State law permits you to revoke your document in the following ways:

1. through a signed and dated writing showing your intent to revoke;
2. by physically destroying the original, or having someone destroy it for you in your presence at your direction;
3. by orally expressing your intent to revoke; or
4. by executing a new Advance Directive that supersedes the older document.

You should notify your health care provider and surrogate(s) to ensure that your revocation is effective.

If you name your spouse as your surrogate and you are divorced or your marriage is subsequently annulled, your spouse's powers as surrogate will be automatically revoked. If you would like your spouse's powers to continue in the event of a divorce or annulment, you can

state this in the "Specific instructions" section on page 2 of the form by adding an instruction such as, "The authority of my surrogate shall not be revoked by divorce or annulment of our marriage."

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

INSTRUCTIONS

PRINT YOUR NAME

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

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

Part One. Designation of Health Care Surrogate

I,_____,
designate as my health care surrogate under s. 765.202, Florida Statutes:

Name: _____
Address: _____
Phone: _____

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name: _____
Address: _____
Phone: _____

Part One. Instructions for Health Care

INITIAL THE SPACES THAT PRECEDE ANY AUTHORITY YOU WISH TO GIVE TO YOUR HEALTH CARE SURROGATE

I authorize my health care surrogate to:

(_____) Receive any of my health information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

(_____) Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

AT THE BOTTOM, ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES. ATTACH ADDITIONAL PAGES IF NEEDED

(_____) Specific instructions and restrictions:

_____

_____

_____

While I have decisionmaking capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

(1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
(2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;
(3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION; OR
(4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.

MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

IF I INITIAL THIS BOX [___], MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

IF I INITIAL THIS BOX [___], MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

INITIAL IF YOU WISH TO GIVE YOUR HEALTHCARE SURROGATE AUTHORITY TO RECEIVE YOUR HEALTH INFORMATION NOW

INITIAL IF YOU WISH TO GIVE YOUR HEALTHCARE SURROGATE AUTHORITY TO MAKE HEALTH CARE DECISIONS NOW

DATE THE DOCUMENT

PRINT YOUR NAME

INITIAL ALL CONDITIONS THAT APPY

ADD SURROGATE NAME AND ADDRESS

ADD ADDITIONAL INSTRUCTIONS, IF ANY

Part Two. 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 dohereby declare that, if at any time I am incapacitate and:

(initial all that apply)

_____ I have a terminal condition, or

_____ I have an end-stage condition, or

_____ I am in a persistent vegetative state

and if my primary 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 orsurgical 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: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

_____

_____

_____

ORGAN DONATION (OPTIONAL)

INITIAL ONLY ONE OF THE FOUR OPTIONS

IF YOU HAVE ALREADY ARRANGED TO DONATE YOUR ORGANS TO A SPECIFIC DONEE, INITIAL THIS OPTION, AND INDICATE THE DETAILS OF YOUR ARRANGEMENT HERE

ORGAN DONATION (OPTIONAL)

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (initial one choice below):

_____ any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;

_____ only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education:

_____
_____
_____

_____ my body for anatomical study if needed. Limitations or special wishes, if any:

_____
_____
_____

_____I have already arranged to donate

_____ Any needed organs, tissues, or eyes,

_____ The following organs, tissues, or eyes:

_____
_____
_____

to the following donee:_____

Phone:_____

Address:_____

_____Zip Code:_____

SIGN AND DATE THE DOCUMENT

PRINT YOUR NAME AND ADDRESS

TWO WITNESSES MUST SIGN, DATE, AND PRINT THEIR ADDRESSES

Part Three. Execution

Signature Date

Printed Name

Address

City State

SIGNATURES OF WITNESSES:

Signature of First Witness Date

Printed Name of First Witness

Address of First Witness

City State Zip

Signature of Second Witness Date

Printed Name of Second Witness

Address of Second Witness

City State Zip