

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE

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:

Name: _____

Address: _____

Phone: _____ Zip Code: _____

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

Name: _____

Address: _____

Phone: _____ Zip Code: _____

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.

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:

Name: _____

Address: _____

Name: _____

Address: _____

Signed: _____ Date: _____

Witness _____
(sign and print name)

Address _____

Witness _____
(sign and print name)

Address _____