Main Office
2315 West Jackson Street, Pensacola, FL 32505
T 850.436.4630 | **F** 850.912.8779
HealthcareWithinReach.org

community health
northwest florida
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LIVING WILL & APPOINTMENT OF HEALTHCARE SURROGATE

I _____, want to choose how I will be treated by my physicians and other healthcare providers. If there comes a time when I am unable to communicate or make my own healthcare decisions because of illness or injury, I direct my physician, my healthcare surrogate and my family to honor this Living Will.

PART 1 – Appoint a Healthcare Surrogate

In the event I am unable to communicate or I am incapable of making decisions about receiving, withholding or withdrawing medical procedures or other treatments, I designate my healthcare surrogate to make choices for me according to his/her understanding of my wishes and values.

My Appointed Healthcare Surrogate is:	
Name:	
Address:	
Phone:	Alternate Phone:

If my surrogate is unable or unwilling, then my next choice (Alternate Surrogate) is:	
Name:	
Address:	
Phone:	Alternate Phone:

PART 2 – Indicate Your Wishes

I understand that this Living Will only becomes effective when I am no longer able to communicate or when I am not capable of making my healthcare decisions. When two physicians have determined that I have one of the following:

- *A terminal or end-stage condition and there is little or no chance of recovery*
- *A condition of permanent and irreversible unconsciousness such as coma or vegetative state*
- *An irreversible and severe mental or physical illness that prevents me from communicating with others, recognizing my family and friends or caring for myself in any way*

then I want my doctors and others to provide comfort (palliative) care including relief of all physical pain, suffering and mental anguish. If I develop one of the above conditions, my treatment choices are:

My Specific Choices if I Have One of the Above Conditions	**Yes I Want**	**No I Do Not Want**
	Circle Yes or No	
Cardio-pulmonary resuscitation (CPR) if my heart or breathing stops	Yes	No
A breathing machine if I am unable to breathe on my own	Yes	No
Nutrition and fluids through tubes in my veins, nose or stomach	Yes	No
Kidney dialysis, a pacemaker or defibrillator or other such machines	Yes	No
Surgery or admission to a hospital intensive care unit	Yes	No
Medications that can prolong my dying, such as antibiotics	Yes	No
I want Hospice involved in my care at the earliest opportunity	Yes	No

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If a medical decision has to be made for me and my decision is not indicated above, I want my healthcare surrogate to make and communicate these decisions for me.

Other Information (optional):

_____

_____

_____

_____

_____

_____

_____

_____

PART 3 – Make it Legal

I fully understand the meaning of this declaration. I am emotionally and mentally competent to make this declaration and have given this careful consideration.

_____ _____ _____
Signature **Date** **Print Name**

Witness 1:_____ _____
Signature of Witness 1 Print Name of Witness 1

Address: _____

Witness 2:_____ _____
Signature of Witness 2 Print Name of Witness 2

Address: _____

* Your healthcare surrogate(s) CANNOT serve as a witness to this Living Will. At least one witness MUST be someone other than your spouse or a blood relative.