Designation of Health Care Surrogate

Name ____________________________________________________________

In the event 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 ____________________________________________________________
Street Address ______________________________________________________
City ___________________________ State _______ Zip ________________
Phone ____________________________

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

Name ____________________________________________________________
Street Address ______________________________________________________
City ___________________________ State _______ Zip ________________
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; or 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: ___________________________________________ Name: ______________________

Signed: ______________________________________ Date:_____________________

Witnesses: 1. ______________________________________ 2. ______________________

Witness must not be a husband, wife, or a blood relative of the principal.
The health care surrogate cannot act as a witness.

Your attorney or health care provider may be able to assist you with forms or further information.

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —