Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203

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 —