

My Wishes”

DESIGNATION OF HEALTH CARE SURROGATE

In the event that I _____, age _____ have been determined by my physician(s) to be incompetent/incapacitated (lack the ability) to provide informed consent for medical treatment (including but not limited to the withholding, withdrawal or continuation of life-prolonging procedures), surgical or diagnostic procedures, or mental health, I wish to designate as my health care surrogate to make health care decisions on my behalf consistent with my wishes, values and beliefs (“Surrogate”):

Name: _____ / _____ Phone # (W) _____
Relationship (H) _____

Address: _____

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

Name: _____ / _____ Phone # (W) _____
Relationship (H) _____

Address: _____

I fully understand that my Surrogate may make all health care decisions, including mental health, on my behalf until I regain the ability to personally make health care decisions. These health care decisions may also include, if necessary, the decisions to withhold, withdraw or continue life-prolonging procedures. My Surrogate may also authorize my admission to or transfer from a health care facility and apply for public benefits on my behalf to defray the cost of health care. This designation and authority of Surrogate is to remain in effect only for the duration of my incapacity or incompetency, if any.

Additional Instructions (Optional): _____

Print Your Name	Signature:
Social Security Number	Tel. No. ()
Address	Dated
City State Zip	
Witness-Print Name	Signature:
Address	Tel No. ()
City State Zip	
Witness-Print Name:	Signature:
Address	Tel. No. ()
City State Zip	

Health Care surrogates may NOT serve as a witness to this document. One witness may be your spouse or blood relative, but second witness must be neither.



FLORIDA HOSPITAL
DeLand

