LIVING WILL

I _____, age _____, am mentally competent and want to choose how I will be treated during the last days of my life. This document supersedes any prior health care advance directive (oral or written), which is inconsistent with my wishes hereunder. I request to be given medical treatment fully sufficient to prevent unnecessary suffering, including pain, suffocation, and physiological, emotional and/or psychological stress. When I can no longer make my own health care choices, I direct my physician(s), other health care providers, and my health care surrogate(s) or anyone acting on my behalf to follow the advance directives of this document. My choices about treatments for four conditions that have little or no chance of recovery are:

Treatment Choices for Conditions that have Little or No Chance of Recovery

(Checking *"YES"* means I *WANT* the treatment for the condition listed. Checking *"NO"* means I *DO NOT WANT* the treatment for the condition listed.)

If diagnosed with:	I want CPR (Heart/Lung Resuscitation)		I want Life Support (by ventilator or respirator)		I want Surgery, Blood, Antibiotics, Lab Studies, etc.		I want Feeding by Vein or Stomach Tube	
End Stage Disease:	Yes	No	Yes	No	Yes	No	Yes	No
Permanent Unconcious State:	Yes	No	Yes	No	Yes	No	Yes	No
Permanent Confusion:	Yes	No	Yes	No	Yes	No	Yes	No
Total Dependence:	Yes	No	Yes	No	Yes	No	Yes	No

Other Instructions: _____

_____

_____

_____

Should I meet medical criteria, I do ____ I do not ____ wish to donate my organs and/or tissues for the benefit of others.

I hereby hold harmless my physicians and any other health care providers who render care or withhold treatment from me in good faith, if they reasonably believe such action(s) is/are consistent with my expressed wishes. I further request that my family and anyone acting on my behalf follow my wishes and directives and take whatever steps are necessary, including legal action, to ensure that my wishes and directives are carried out. I direct my Power of Attorney or Trustee holding funds on my behalf to make such funds available to any health care surrogate or anyone acting on my behalf to ensure that my wishes, as expressed herein, are carried out.

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
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ADVDIRECT