**GENERAL DURABLE POWER OF ATTORNEY**

FSA 709-1 et seq.

**I**, \_\_\_\_\_\_\_YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ having an address at

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YOUR ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby make, constitute and appoint the following people to be and act as my attorney-in-fact in the order set forth below:

First Choice: \_\_\_\_\_\_\_\_\_\_\_\_PERSON’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second Choice: \_\_\_\_\_\_\_\_\_ PERSON’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Third Choice: \_\_\_\_\_\_\_\_\_\_\_PERSON’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If more then one person is named as first, second or third choice, they shall act together. If one is unable to act, the other shall act alone.

TO ACT in my name, place and stead to do and perform any and all acts and deeds in any way which I could do myself, if I were personally present, to the extent permitted by law:

(a) To request, demand, seek, sue for, recover, accept and receive any and all kinds of goods, chattels, debts, rents, interest, sums of money and demands whatsoever and wherever situate, that are due or become due, and to execute, acknowledge and deliver acquittances, receipts, releases, satisfactions or other discharges for the same;

(b) To make, execute, endorse, accept, negotiate and deliver in my name or in the name of my attorney(s)-in-fact any and all checks, notes, drafts, warrants, securities, stock cer­tificates, certificates of deposit, bonds, acknowledg­ments, and any other agreements, certificates or in­struments of any nature, as my attorney(s)-in-fact may deem necessary or appropriate;

(c) To cause securities or other property to be held or registered in the name of a nominee or nominees or in any other form; to vote any and all shares of stock or other securities and to execute proxies or other in­struments with respect to such stock or securities; to exercise or trade stock options;

(d) To deposit or withdraw any sums in any bank, savings, credit union, money market or similar account maintained by me; to open or close any such accounts; to have access to and remove from or add to the contents of any safe deposit box in my name; and

delegate duties hereunder and pay such compensation, as my attorney(s)-in-fact may deem necessary or appropriate; and

(j) To act on my behalf with respect to Federal, state and local income, gift, estate and other taxes of any kind or period, including without limitation the signing of returns, receipts or refunds, waivers and consents, and all other tax matters that I could perform myself if able to do so; and

1. To do, execute, perform and finish for me and in my name all things which my

attorney(s)-in-fact shall deem necessary or appropriate, in and about or concerning any and all of my property or any part thereof;

1. To open, read, and as appropriate, redirect, answer or otherwise handle and dispose of my mail;
2. To cancel the use of my credit cards or lines of credit;
3. To transfer to the Trustee of any Revocable Trust of which I am a Trustor and Beneficiary, any of my assets that may remain in my name alone or in my name with other individuals;
4. To convey or accept legal title to any and all real estate, in the form deemed most appropriate by my agent acting as Power of Attorney;
5. To perform any and all other acts and deeds permitted by law in any state in which this Power of Attorney may need to be exercised.
6. \_\_\_\_\_\_\_ To do any and all acts necessary for me to become Medicaid eligible including making gifts to decrease assets level and setting up a qualified income trust. This specific power shall only be granted if initialed by me. INITIAL HERE IF YOU WANT THIS PROVISION IN YOUR POWER OF ATTORNEY

 To induce any third party to act hereunder, I hereby agree that any third party receiving a duly executed copy or facsimile copy of this General Durable Power of Attorney may act hereunder, and that revocation or termination hereof shall not be ineffective as to such third party unless and until actual notice or knowledge of the revocation or termination shall have been received by such third party.

This power shall not be affected by disability of the Principal: All acts done by my Attorney pursuant to this Power during any period of disability or incompetence or uncertainty as to whether I am dead or alive shall have the same effect and inure to the benefit of and bind me or my heirs, devisees, personal representatives, and successor trustees as if I were alive, competent and not disabled.

 I specifically direct that the person exercising this Power of Attorney keep a written record of all acts performed pursuant to the exercise of this Power of Attorney including all financial transactions performed on my behalf. This record shall include the dates of each such act, a detailed summary of the act performed and the reason for such act. Once every \_\_\_\_\_\_\_\_\_\_\_\_\_\_ months or \_\_\_\_\_\_\_\_\_\_\_ days, the person exercising this Power of Attorney shall furnish a copy of this written report to the following named people:

USE THIS PROVISION IF YOU WANT THE PERSON WHO HAS YOUR POWER OF ATTORNEY TO REPORT TO OTHER PEOPLE, HOW OFTEN TO REPORT AND WHO THOSE PEOPLE ARE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the person exercising my Power of Attorney fails to make these reports to the people named above, it shall be grounds for the people entitled to receive a copy of the report to have the person exercising this Power of Attorney removed and the next alternate named herein to take that person’s place as my Power of Attorney.

No one shall ever use this Power of Attorney to change or revoke my Will, Trust, Beneficiary Deed, Living Will, Health Care Power of Attorney, the beneficiary(ies) on my IRA’s, Life Insurance, Annuities, Pay On Death Provisions on my bank accounts or Transfer On Death Provisions on my stocks and bonds unless I specifically appoint someone with these powers in writing that is witnessed by two people and notarized.

**THIS POWER OF ATTORNEY SHALL BECOME EFFECTIVE AT THE TIME IT IS SIGNED, WITNESSED AND NOTARIZED.**

I, \_\_\_\_\_\_\_\_YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the Maker and Principal, sign my name to this Power of Attorney this \_\_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_, and being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my Power of Attorney and that I sign it willingly, or willingly direct another to sign it for me, that I execute it as my free and voluntary act for the purposes expressed in the Power of Attorney and that I am eighteen years of age or older, of sound mind and under no constraint or undue influence.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Maker

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Witness Signature

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE OF FLORIDA, COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, SS.:

 The foregoing instrument was sworn to and acknowledged before me on the \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_, by \_\_\_\_\_\_\_\_\_\_\_YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as Principal and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as Witnesses to be known or provided the following identification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

**LIVING WILL - ADVANCE DIRECTIVE FOR MEDICAL / SURGICAL TREATMENT**

**Definitions:**

**Life-Sustaining Procedure:** Any medical procedure or intervention that, if administered to a qualified patient, would serve only to prolong the dying process. A life-sustaining procedure shall not include any medical procedure or intervention for nutrition and hydration of the qualified patient or considered necessary by the attending physician to provide comfort or alleviate pain. However, artificial nutrition and hydration may be withdrawn or withheld.

**Persistent Vegetative State**: A medical state in which an attending physician and another doctor, qualified to make such diagnosis, agree that within a reasonable degree of medical probability the patient can no longer think, feel anything, knowingly move, or be aware of being alive. The physicians must agree this condition will last indefinitely without hope for improvement and must have monitored the patient long enough to make that decision. A Persistent Vegetative State is defined by reference to the criteria and definitions employed by prevailing community medical standards of practice, and not by the definition above.

**Terminal Condition**: An incurable or irreversible condition for which the administration of life sustaining procedures will serve only to postpone the moment of death.

**Declaration**

I,\_\_\_\_\_\_\_YOUR NAME \_\_\_\_\_\_\_\_\_\_\_, being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below, and I hereby declare that:

**Terminal Condition: Life-Sustaining Procedures:**

If at any time my attending physician and one other physician who is qualified to certify in writing that I have a terminal condition and I am unable to effectively receive or evaluate information, or communicate decisions concerning my person, then: **(Select only one) INITIAL ONE ONLY**

\_\_\_\_(Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration and that I only be administered those medical procedures to alleviate pain and make the dying process as comfortable as possible.

\_\_\_\_(Initials) I direct that life-sustaining procedures shall be continued for a period of \_\_\_\_\_ days, and if there is no change in my condition that would indicate to my physicians that my prognosis has improved, then I direct that all life-sustaining procedures be withdrawn and/or discontinued except for medical procedures to alleviate pain and make the dying process as comfortable as possible.

\_\_\_\_(Initials) I direct that life-sustaining procedures shall be continued indefinitely, regardless of my medical prognosis, if medically feasible in the opinion of my doctor(s).

**Persistent Vegetative State: Life-Sustaining Procedures**:

 If at any time my attending physician and one other qualified physician certify in writing that I am in a persistent vegetative state, then: **(Select only one) INITIAL ONE ONLY**

 \_\_\_\_(Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration and that I only be administered those medical procedures to alleviate pain and make the dying process as comfortable as possible.

\_\_\_\_(Initials) I direct that life-sustaining procedures shall be continued for a period of \_\_\_\_\_ days, and if there is no change in my condition that would indicate to my physicians that my prognosis has improved, then I direct that all life-sustaining procedures be withdrawn and/or discontinued except for medical procedures to alleviate pain and make the dying process as comfortable as possible.

\_\_\_\_(Initials) I direct that life-sustaining procedures shall be continued indefinitely, regardless of my medical prognosis, if medically feasible in the opinion of my doctor(s).

**Other Medical Directives**

If you have other medical directives list them here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FOR EXAMPLE: DO NOT RESUSCITATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resolution with Medical Power of Attorney: (Select only one) INITIAL ONE ONLY**

 \_\_\_\_(Initials) My Agent under my Medical Power of Attorney shall have the authority to override my preferences as stated in this instrument, whether this instrument was executed before or after appointment of my Agent under my Medical Power of Attorney.

\_\_\_\_(Initials) My preferences as stated in this instrument shall prevail over the wishes of my Agent under my Medical Power of Attorney, whether this instrument was executed before or after appointment of my Agent under my Medical Power of Attorney.

**Notification of Interested Parties (HIPAA RELEASE)**

In the event that I have a terminal condition, or I am diagnosed as being in a Persistent Vegetative State, in addition to my Agents under Medical Power of Attorney, I direct my medical care providers to notify and discuss my medical situation with the individuals listed below. I hereby waive any requirements of Public Law 104-191 and supporting CFRs, otherwise known as the Health Insurance Portability and Accountability Act of 1996, as amended, or HIPAA, concerning release of medical information by my medical care providers to these individuals. This direction does NOT authorize these individuals to make medical decisions on my behalf, unless such person(s) also are my Agent under Medical Power of Attorney. (This section shall be considered valid regardless of whether or not the categories of relationship and telephone number are completed.) FILL IN FOR THE PEOPLE YOU WANT TO HAVE ACESS TO YOUR HEALTH CARE PROVIDERS

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ANATOMICAL GIFTS**: I hereby authorize the following acts with regard to donation of my organs, tissue, bone, corneas, and other components of my body: INITIAL ONE

\_\_\_\_(Initials) I wish to be an organ and/or tissue donor, if medically feasible.

\_\_\_\_(Initials) I do not wish to be an organ and/or tissue donor.

I execute this declaration, as my free and voluntary act, this day of , 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Declarant

**Declaration of Witnesses**

The foregoing instrument was signed and declared by \_\_\_\_\_YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_ to be the declarant’s declaration, in the presence of us who, in the presence of the declarant, in the presence of each other, and at the declarant’s request, have signed our names below as witnesses, and we declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. I did not sign the declarant’s signature, and I am not a physician; an employee of the attending physician or health care facility in which the declarant is a patient; a person who has a claim against any portion of the estate of the declarant at the declarant’s death at the time this declaration was signed; a person who knows or believes I am entitled to any portion of the state of the declarant upon the declarant’s death either as a beneficiary of a Will in existence at the time this declaration was signed, or an heir at law; nor a patient in the health care facility where the declarant resides. I am eighteen (18) years of age or older, and under no form of coercion, undue influence or otherwise disqualifying disability.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Signature of Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of Florida }

County of }

SUBSCRIBED and sworn to before me by \_\_\_\_\_\_\_\_\_\_\_YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , the declarant, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, witnesses, as the voluntary act and deed of the declarant this\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_ to me personally known or who provided the following identification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission Expires

**HEALTH CARE SURROGATE (POWER OF ATTORNEY)**

**TO:** My family, physicians and all those concerned with my care:

 I, \_\_\_\_\_\_\_\_YOUR NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Maker) presently residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_YOUR ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and being an adult of sound mind, hereby appoint and authorize the following people in the order set forth below to be and act as my agent and attorney(s)-in-fact to act for me and in my name to make and communicate any and all decisions about or relating to my receipt or refusal to accept medical treatment, hospitalization, health care or personal care, in any situation in which, as the re­sult of illness, disease, mental deterioration or injury, I am in­capable of making or communicating a decision with respect to my treatment or care. This authorization includes the right to refuse and direct the withdrawal of medical treatment which would prolong my life, and to communicate health care decisions to all persons including without limitation my physicians, health care providers and family.

First Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_PERSON’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second Choice: \_\_\_\_\_\_\_\_\_\_\_\_PERSON’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Third Choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_PERSON’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If I lose the ability to make or communicate medical de­cisions, I hereby authorize my agent and attorney(s)-in-fact named herein to terminate all life support measures if I have, am in or suffer from any of the conditions set forth in my Living Will. My agent or attorney(s)-in-fact shall have the authority to order the administration of medication or the perfor­mance of any medical procedure deemed necessary to keep me comfort­able and to relieve pain. The procedures and treatment to be with­held and withdrawn include, without limitation, surgery, antibiot­ics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered feeding and fluids.

 I further delegate to my agent and attorney(s)-in-fact the power and authority to select, employ and discharge health care personnel, such as physicians, nurses, therapists, home health care providers and other medical professionals, and to contract in my name and on my behalf for all health care services, including with­out limitation medical, nursing and hospital care, as my agent and attorney(s)-in-fact may deem appropriate. I confirm that I shall be and remain personally liable for the payment of all such care and services to the same extent as if I had personally contracted therefore.

 I further authorize my agent and attorney(s)-in-fact to request, receive and review any information regarding my physical or mental health, including without limitation medical and hospital records; to execute on my behalf any releases or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. I authorize my agent and attorney(s)-in-fact to execute on my behalf any documents necessary or desirable to implement the health care decisions that my agent and attorney(s)-in-fact is authorized to make pursuant to this document, including without limitation all documents pertain­ing to a refusal to permit medical treatment, or authorizing the leaving of a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider.

 This document is a Durable Power of Attorney and the authority of my agent and attorney-in-fact shall not terminate if I become disabled, incompetent or incapacitated. It is a health care directive made pursuant to law, and it shall continue in effect for all who may rely on it, except those to whom I hereafter may give notice of its revocation.

 All actions of my agent and attorney(s)-in-fact under this directive during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

 **IN WITNESS WHEREOF**, I have executed this instrument, as my free and voluntary act and deed, this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Maker’s Signature

**Declaration of Witnesses**

The foregoing instrument was signed and declared by\_\_\_\_YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to be the declarant’s declaration, in the presence of us who, in the presence of the declarant, in the presence of each other, and at the declarant’s request, have signed our names below as witnesses, and we declare that, at the time of the execution of this instrument, the declarant, according to our best knowledge and belief, was of sound mind and under no constraint or undue influence. I did not sign the declarant’s signature, and I am not a physician; an employee of the attending physician or health care facility in which the declarant is a patient; a person who has a claim against any portion of the estate of the declarant at the declarant’s death at the time this declaration was signed; a person who knows or believes I am entitled to any portion of the state of the declarant upon the declarant’s death either as a beneficiary of a Will in existence at the time this declaration was signed, or an heir at law; nor a patient in the health care facility where the declarant resides. I am eighteen (18) years of age or older, and under no form of coercion, undue influence or otherwise disqualifying disability.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Signature of Witness

Address: Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of Florida }

County of }

SUBSCRIBED and sworn to before me by \_\_\_\_\_\_\_YOUR NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , the declarant, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, witnesses, as the voluntary act and deed of the declarant this\_\_\_\_\_\_day of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_ to me personally known or who provided the following identification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission Expires