LONG TERM
CARE SOLUTIONS, LLC

DESIGNATION OF HEALTH CARE SURROGATE
(Florida Statutes 765-203)

Name:

_____

(Last) (First) (Middle Initial)

In the event that 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: _____

Address: _____

_____

Zip Code: _____ Phone: _____

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

Name: _____

Address: _____

_____

Zip Code: _____ Phone: _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to 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:

_____

Signed:

_____

Date: _____

WITNESSES:

Signature: _____
Printed Name: _____
Address: _____

Signature: _____
Printed Name: _____
Address: _____