LIVING WILL DECLARATION/MEDICAL POWER OF ATTORNEY

OF

XXX

This Declaration is made this ______ day of _________________, 2012. I,___________, of Miami-Dade County, Florida willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have a terminal condition and if my attending physician has determined that there can be no recovery from such condition and that my death is imminent, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain, including but not limited hydration, pain medication, and other methods to make me comfortable. Notwithstanding the foregoing, if I am still able to communicate, no physician shall have the power to initiate the withdrawal of life prolonging procedures unless I so direct.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

Should I become comatose, incompetent or otherwise mentally or physically incapable of communication, or of making medical treatment decisions for myself, I authorize ___________, ________________ to make all medical treatment decisions on my behalf, in accordance with my

Living Will Declaration, and to have access to all of my medical records. I have discussed my wishes concerning terminal care with her, and I trust her judgment on my behalf with regard to all medical matters, including but not limited to the issue of a terminal situation.

I recognize that the above paragraph may result in my not receiving aggressive treatment such as intubation, ventilator care, cardiac massage, defibrilation, cardioversion, and intravenous cardiac medications. The above individual may shall have the power to determine that I not receive any of the above, or in their discretion, only receive same for a limited period of time.

I understand the full import of this document and I am emotionally and mentally competent to execute it.

____

The Declarant is known to me and I believe him to be of sound mind.

____
Witness

____
Witness

STATE OF FLORIDA)
) ss:
COUNTY OF MIAMI-DADE)

I, ____________________, Notary Public, hereby certify that ______________ and ________________, witnesses, personally known to me to be the same persons whose names are