DESIGNATION OF HEALTH CARE SURROGATE

Patient’s name and address: Smith, John Adam Sr., 1111 Adams St., Tallahassee, FL 32301

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:

John Adam Smith Jr.

1111 Adams St.

Tallahassee, FL 32301

Home Phone: 111.555.0140

Work Phone: 111.555.1851

Cell Phone: 111.555.7399

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

Jason Adams

210 Auburn Lane

Miami, FL 33010

Home Phone: 111.887.5741

Cell Phone: 111.663.3218

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.

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(s) so they may know who my surrogate(s) are: Melissa Sensen, Krueger Lane, Apt. 3, Tampa, FL, 32222.

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Signature of Patient Signature of Witness Signature of Witness