PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

Patient Name: ______________________ Date of Birth: _________ Today's Date: _______

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

{ } I have made such a declaration
{ } I have NOT may such a declaration

Health Care Surrogate

{ } I have designated a Health Care Surrogate
{ } I have NOT designated a Health Care Surrogate

Durable Power of Attorney

{ } I have appointed a Durable Power of Attorney for Health Care decisions.
{ } I have NOT appointed a Durable Power of Attorney for Health Care decisions.

____________________________________ ____________________________________
Patient's or Representative's Signature Date Signed

YEARLY RECONFIRMATION: By signing below I acknowledge that the above information remains accurate.

Patient's or Representative's Signature	Date Signed
Patient's or Representative's Signature	Date Signed
Patient's or Representative's Signature	Date Signed
Patient's or Representative's Signature	Date Signed
Patient's or Representative's Signature	Date Signed
Patient's or Representative's Signature	Date Signed
Patient's or Representative's Signature	Date Signed
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