ADVANCE RESEARCH &
HUMAN DEVELOPMENT LLC
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# "Deciding to Donate"

**Every individual has the opportunity to choose organ and tissue donation at the time of their death. This includes the decision to donate organs and tissues for research and educational purposes. This right is protected by law in the State of Florida as long as your wishes are in writing.**

**ARAHD provides the opportunity to fulfil the wishes of donors and families by collaborating with Universities, Researchers, and Biotechnology Companies to help study numerous diseases and advance treatments and find cures.**

## Important Facts to Remember:

- **Executing a living will** - remember your decision to donate organs and tissues needs to be in writing.
- **Complete a Health Care Surrogate Form** - this allows you to give others the decision making power, in the event you have not made a decision and can no longer make one.
- **Sign a Final Disposition Authorization Form** – this allows you to say what you want done with your body and who should be in charge of it.
- **Appropriate Distribution of Paperwork** – give copies to your attorney, your physicians, your family or appointed surrogate, and keep them available for Emergency Services to find quickly.
- **Inform Your Family of Your Choices** – when family members are informed of your decisions it allows for a smooth process, and they understand your decision. Many families approached with the opportunity for donation are thankful they knew their loves ones decision or wish they knew what their loved on would have wanted.

## State of Florida Legal Next of Kin (in order as required by law FS 497.005):

1. **Surviving Spouse**
2. **Adult Children**
3. **Parent**
4. **Adult Brother/Sister**
5. **Adult Grandchild**
6. **Grandparent**
7. **Any Other Adult Next of Kin**
8. **Guardian of the Decedent at Time of Death**
9. **Personal Representative of the Deceased**
10. **Attorney in fact at Time of Death**
11. **Health Surrogate at the Time of Death**
12. **Public Health Officer**
13. **The Medical Examiner, County Commission, or Administrator**
14. **Representative of the Nursing Home or other Health Care Institution**
15. **Friend or Other Person Willing to Assume Responsibility**

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# Final Disposition Authorization

***FS 497.005 Definitions. (37) "Legally authorized person"*** *means, in the priority listed, the decedent, when written inter vivos authorizations and directions are provided by the decedent; the surviving spouse, unless the spouse has been arrested for committing against the deceased an act of domestic violence as defined in s. 741.28 that resulted in or contributed to the death of the deceased; a son or daughter who is 18 years of age or older; a parent; a brother or sister who is 18 years of age or older; a grandchild who is 18 years of age or older; a grandparent; or any person in the next degree of kinship. In addition, the term may include, if no family member exists or is available, the guardian of the dead person at the time of death; the personal representative of the deceased; the attorney in fact of the dead person at the time of death; the health surrogate of the dead person at the time of death; a public health officer; the medical examiner, county commission, or administrator acting under part II of chapter 406 or other public administrator; a representative of a nursing home or other health care institution in charge of final disposition; or a friend or other person not listed in this subsection who is willing to assume the responsibility as the legally authorized person. Where there is a person in any priority class listed in this subsection, the funeral establishment shall rely upon the authorization of any one legally authorized person of that class if that person represents that she or he is not aware of any objection to the cremation of the deceased's human remains by others in the same class of the person making the representation or of any person in a higher priority class.*

***I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. Pursuant to the legal authority given to me by Florida Statutes, I am hereby declaring that the final disposition of my human remains shall be by the method I have initialed below:***

_____ (Initial) Burial or Entombment in:
Cemetery Name:_____
City, State_____

_____ (Initial) Cremation
With Cremated Remains to be given to:_____
who shall have authority to have my remains released and arrange for it in lieu of any other person(s) if I have not already prearranged for it myself.

_____ (Initial) Anatomical Donation of Organs, Eyes, and Tissues for
- Transplantation _____ (Initial)
- Research and Education _____ (Initial)

_____ (Initial) Sea Burial of Casketed Remains

X_____
Signature
Printed Name:_____
Date of Birth:_____ SS #:_____

**Witness: #1**

X_____
Signature

_____
Printed Name

_____
Address

_____
City, State Zip Phone

**Witness: #2**

X_____
Signature

_____
Printed Name

_____
Address

_____
City, State, Zip Phone

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**LIVING WILL**

Declaration made this _____ day of _____20__, I, _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and (initial one or more of the following three conditions)

_____(initial) I have a terminal condition
or _____(initial) I have an end-stage condition
or _____(initial) I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, 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.

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.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____
Address: _____
_____
Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____

Signed: X_____ Date: _____

**Witness: #1**
X_____
Signature

_____
Printed Name

_____
Address

_____
City, State, Zip

**Witness: #2**
X_____
Signature

_____
Printed Name

_____
Address

_____
City, State, Zip

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## DESIGNATION OF HEALTH CARE SURROGATE

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: _____
City, State, Zip _____
Phone: _____

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

Name: _____
Address: _____
City, State, Zip _____
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: _____Phone_____
Name: _____Phone_____
Name: _____Phone_____

Signed: X_____ Date: _____

**Witness: #1**
X_____
Signature

_____
Printed Name

_____
Address

_____
City, State Zip Phone

**Witness: #2**
X_____
Signature

_____
Printed Name

_____
Address

_____
City, State, Zip Phone