LIVING WILL (HEALTH CARE DIRECTIVE)

This form was completed and signed on 4th day of June 2025.

I, Carl Holland, with a street address of 1307 Travis Street, City of Miramar, County of Broward, State of Florida, with the last four (4) digits of my social security number (SSN) being XXX - XX - 123 (Hereinafter referred to as the 'Principal') desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

A. LIFE SUPPORT

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

CH ☒ - Chronic coma or persistent vegetative state

_____ ☐ - no longer able to communicate my needs

CH ☒ - no longer able to recognize family or friends

_____ ☐ - total dependence on others for daily care

_____ ☐ - Other: _____.

Initial and check only one:

_____ ☐ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

CH ☒ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

B. CERTAIN LIFE-SUSTAINING TREATMENT: (You do not have to initial and check any of the options below if you do not wish to)

Some people do not wish to have certain life sustaining treatments under any circumstance, even if recovery is a possibility. Check treatments below, if any, that you do not wish to have under any circumstances:

_____ ☐ - Cardiopulmonary Resuscitation (CPR)

_____ ☐ - Ventilation (breathing machine)

__CH__ ☒ - Feeding tube

_____ ☐ - Dialysis

_____ ☐ - Other: _____.

C. END OF LIFE WISHES (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that: When I am in the hospital, I would like to be in as little pain as possible. I would like to get the chance to say goodbye to my family and close friends. After my death, I would like a celebration of my life instead of a standard funeral.

_____

_____

_____

_____.

I have signed this document on this __4th__ day of June _____ 2025__.

Carl Holland _____
Principal's Signature

Carl Holland _____
Print Nam

WITNESS ACKNOWLEDGMENT

On the date set forth above, I hereby state as follows:

The above named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old and not related to him/her by blood, marriage or adoption. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

WITNESS 1

Theo Beaumont
Signature

Theo Beaumont
Print Name

3015 Terry Lane, Melbourne, Florida 32935
Address

321-123-1010
Phone Number

WITNESS 2

Abi Gibbs
Signature

Abi Gibbs
Print Name

1542 Virgil Street, Miramar, Florida 33025
Address

754-123-4567
Phone Number

NOTARY ACKNOWLEDGMENT

State of _____ }

County of _____ }

Signed and the ____ day of _____, 20____.

I, the unde aid County in said State, hereby certify that the

Principal _____ igned above in this living will, and who is known to me, acknowledged being informed of the contents of the said document, (s)he executed the the same bears date.

Given under my hand this ____ day of _____

Notary Public Signature: _____

Printed Name: _____

My commission expires: _____

(Notary Seal)

Notarization not required in FL per § 765.202(1)