



made under the *Medical Treatment*Planning and Decisions Act 2016 (Vic.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Your medical treatment decision maker has legal authority to make medical treatment decisions on your behalf, if you do not have decision-making capacity to make the decision.

Your medical treatment decision maker is the first person you list below who is reasonably available, and willing and able to make the decision. Only adults can appoint a medical treatment decision maker.

Part 1: Personal details

Before you start, read the checklist of steps with this form.

You must fill in your full name, date of birth and address. A phone number is optional.

Your full name:			
Date of birth: (dd/m	ım/yyyy)		
Address:			
Phone number:			

Part 2: Medical treatment decision maker details

This form allows you to appoint up to four people.

I **revoke** any other previous appointment of a medical treatment decision maker however described.

I appoint as my medical treatment decision maker(s):

Fill in the details of your first medical treatment decision maker here.

Medical treatment decision maker 1			
Full name:			
5 4 61141			

Date of birth: (dd/mm/yyyy)

Address:

Phone number:

Fill in the details of your second medical treatment decision maker here.

Cross out this section if you are not appointing a second medical treatment decision maker.

Medical treatment decision maker 2

Full name:	
Date of birth: (dd/m	m/yyyy)
Address:	
Phone number:	

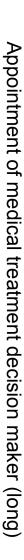




Appointment of medical treatment decision maker (long) (cont.) Appointment by:

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Medical treatmen	t decisio	n maker 3		
Full name:				
Date of birth: (dd/m	ım/yyyy)			
Address:				
Phone number:				
Medical treatmen	t decisio	n maker 4		
Full name:				
Date of birth: (dd/m	ım/yyyy)			
Address:				
Phone number:				
tions or condition	ons (op	otional)		
	Full name: Date of birth: (dd/m Address: Phone number: Medical treatmen Full name: Date of birth: (dd/m Address: Phone number:	Full name: Date of birth: (dd/mm/yyyy) Address: Phone number: Medical treatment decisio Full name: Date of birth: (dd/mm/yyyy) Address: Phone number:	Date of birth: (dd/mm/yyyy) Address: Phone number: Medical treatment decision maker 4 Full name: Date of birth: (dd/mm/yyyy) Address:	Full name: Date of birth: (dd/mm/yyyy) Address: Phone number: Medical treatment decision maker 4 Full name: Date of birth: (dd/mm/yyyy) Address: Phone number:





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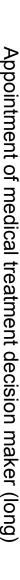
(COIII.)			
Appointment by: (insert your full name)			
Part 4: Witnessin	•		
You must sign in front of two adult witnesses. One witness must be	Signature of per	rson making this appointme	nt (you sign here)
a registered medical practitioner or able to witness affidavits. See justice.vic.gov.au/affidavit for list. Neither witness can be an appointed medical treatment decision maker for you. Refer to the checklist if someone else is signing on your behalf.	appears to have nature and cons previous appoint at the time of sig appeared to free the person signed second witness;	Ining the document, the person madecision-making capacity and appequences of making the appointment; and Ining the document, the person making the document and voluntarily sign the document of the document	pears to understand the ent and revoking any aking this appointment nt; and and in the presence of a
	Witness 1 – Aut		
A registered medical practitioner or someone able to witness affidavits must complete this	Qualification of a	uthorised witness:	
section.			
	Signature of auth	orised witness:	Date: (dd/mm/yyyy)
	Witness 2 – Adu	ılt witness	
Another adult witness must complete this section.	Full name of adu	It witness:	
7.7.1.0	Signature of adul	It witness:	Date: (dd/mm/yyyy)



Appointment of medical treatment decision maker (long) (cont.) Appointment by: (insert your full name)

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Appointment by: (insert your full name)				
If an interpreter is pre	se	nt when this document is witnessed	I	
If an interpreter is present at the time	N	ame of interpreter:		
the document is				
witnessed, they complete this section	lf	accredited with the National Accreditat	tion Auth	nority
immediately after the document is	N	IAATI number:		
witnessed.	la	am competent to interpret from English	into the	following language:
	•	orovided a true and correct interpretation	on to fac	cilitate the witnessing
	S	ignature of interpreter:		Date: (dd/mm/yyyy)
Part 5: Interpreter	ر S	tatement		
•		I in the preparation of this documen	t	
If an interpreter	Ιi	nterpreted in the following language:		
assisted you in preparing this				
document, the interpreter completes this part.		/hen I interpreted into this language the understand the language used in the	•	• •
Cross out Part 5 if		ame of interpreter:		•••
not relevant.		<u></u>		
			<u> </u>	
	N	IAATI number (if accredited):		
	S	ignature of interpreter:		Date: (dd/mm/yyyy)
	1			





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Appointment by:	
(insert your full name)	

Part 6: Statement of acceptance

Each medical treatment decision maker you appoint must read the statement of acceptance and sign in front of an adult witness.

Your first medical treatment decision maker must read this statement of acceptance and sign in front of an adult witness.

Medical treatment decision maker 1

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

	Name of medical treatment decision maker:	
	Signature of medical treatment decision maker:	Date: (dd/mm/yyyy)
Mita and appropriate a	I certify that I witnessed the signing of this stater	ment of acceptance
Vitness completes his section.	Name of adult witness:	nent of acceptance.
	Signature of adult witness:	Date: (dd/mm/yyyy)

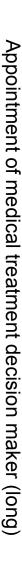


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Appointment by: (insert your full name	
Part 6: Statemer	nt of acceptance (cont.) Medical treatment decision maker 2
If you appoint a second medical treatment decision maker, they must read this statement of acceptance and sign in front of an adult witness. Cross out this section if you are not appointing a second medical treatment decision maker.	 I accept my appointment as medical treatment decision maker and state that: I understand the obligations of an appointed medical treatment decision maker; and I undertake to act in accordance with any known preferences and values of the person making the appointment; and I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment. Name of medical treatment decision maker:
	Signature of medical treatment decision maker: Date: (dd/mm/yyyy)
Witness completes this section.	I certify that I witnessed the signing of this statement of acceptance.

Signature of adult witness:

Date: (dd/mm/yyyy)





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Appointment by:	
(insert your full name)	

Medical treatment decision maker 3

Part 6: Statement of acceptance (cont.)

If you appoint a third medical treatment decision maker, they must read this statement of acceptance and sign in front of an adult witness.

Cross out this section if you are not appointing a third medical treatment decision maker.

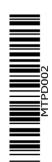
Witness comp this section.

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values
 of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

nent	Name of medical treatment decision maker:	
r.		
	Signature of medical treatment decision make	ker: Date: (dd/mm/yyyy)
letes	I certify that I witnessed the signing of this st Name of adult witness:	atement of acceptance.
	Signature of adult witness:	Date: (dd/mm/yyyy)

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Appointment by: (insert your full name)	
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Part 6: Statement of acceptance (cont.)

If you appoint a fourth medical treatment decision maker, they must read this statement of acceptance and sign in front of an adult witness.

Cross out this section if you are not appointing a fourth med decis

Medical treatment decision maker 4 I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

medical treatment decision maker.	Name of medical treatment decision maker:	
	Signature of medical treatment decision maker:	Date: (dd/mm/yyyy)
Witness completes this section.	I certify that I witnessed the signing of this statement of acceptance.	
	Name of adult witness:	
	Signature of adult witness:	Date: (dd/mm/yyyy)

You have reached the end of this form.

- Please keep your original 'Appointment of medical treatment decision maker' form safe and accessible for when it is needed.
- It is recommended your medical treatment decision maker has read and understood the contents of your advance care directive (if any).
- Your 'Appointment of medical treatment decision maker' form and advance care directive can be uploaded on MyHealth Record and it is recommended copies be shared with your appointed medical treatment decision maker and relevant health practitioner(s) / health service(s).