



Appointment of medical treatment decision maker for someone signing on your behalf

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

Appointment of medical treatment decision maker for someone signing on your behalf

Use this form if you need someone to sign an appointment of medical treatment decision maker for you, at your direction.

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/mm/yyyy) | | |
| Address: | | |
| Phone number: | | |

Part 2: Medical treatment decision maker details

This form allows you to appoint up to two people. To appoint more people, use the long version of this form.

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: | | |
| 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/mm/yyyy) | | |
| Address: | | |
| Phone number: | | |



Appointment of medical treatment decision maker for someone signing on your behalf (cont.)

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Appointment by: (insert your full name)

Part 3: Any limitations or conditions (optional)

Cross out if not including limitations or conditions.

[Empty box for limitations or conditions]

Part 4: Witnessing

If you need someone to sign for you, at your direction, they must be 18 years or older. They cannot be one of the witnesses or the person you are appointing. They sign and date the form at your direction and in front of you and the two witnesses. One witness must be 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.

Someone signing at the direction of the person making this appointment

I sign this appointment at the direction and in the presence of the person making the appointment and in the presence of two witnesses.

Full name of the person making the appointment:

[Empty box for full name of person making appointment]

Full name of person signing at their direction:

[Empty box for full name of person signing at their direction]

Signature of person signing at their direction: Date: (dd/mm/yyyy)

[Empty boxes for signature and date]



Appointment of medical treatment decision maker for someone signing on your behalf (cont.)

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Appointment by: (insert your full name)

Each witness certifies that:

- at the time of the signing the document, the person making this appointment appears to have decision-making capacity and appears to understand the nature and consequences of making the appointment; and
• at the time of signing the document, the person making this appointment appeared to freely and voluntarily direct another person to sign the document; and
• the person who signed the document at the direction of the person making the appointment signed the document in my presence and in the presence of a second witness; and
• I am not the person's appointee under this appointment.

A registered medical practitioner or someone able to witness affidavits must complete this section.

Witness 1 - Authorised witness

Full name of authorised witness:

Qualification of authorised witness:

Signature of authorised witness: Date: (dd/mm/yyyy)

Another adult witness must complete this section.

Witness 2 - Adult witness

Full name of adult witness:

Signature of adult witness: Date: (dd/mm/yyyy)

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Appointment of medical treatment decision maker for someone signing on your behalf (cont.)

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Appointment by: (insert your full name)

If an interpreter is present when this document is witnessed

If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.

Name of interpreter:

If accredited with the National Accreditation Authority
NAATI number:

I am competent to interpret from English into the following language:

I provided a true and correct interpretation to facilitate the witnessing of the document.

Signature of interpreter: Date: (dd/mm/yyyy)

Part 5: Interpreter statement

If an interpreter assisted in the preparation of this document

If an interpreter assisted you in preparing this document, the interpreter completes this part. Cross out Part 5 if not relevant.

I interpreted in the following language:

When I interpreted into this language the person appeared to understand the language used in the document.

Name of interpreter:

NAATI number (if accredited):

Signature of interpreter: Date: (dd/mm/yyyy)



Appointment of medical treatment decision maker for someone signing on your behalf (cont.)

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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:

[Empty text box for name of medical treatment decision maker]

Signature of medical treatment decision maker: Date: (dd/mm/yyyy)

[Empty text boxes for signature and date of medical treatment decision maker]

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

[Empty text box for name of adult witness]

Signature of adult witness: Date: (dd/mm/yyyy)

[Empty text boxes for signature and date of adult witness]

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Appointment of medical treatment decision maker for someone signing on your behalf (cont.)

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Appointment by: (insert your full name)

Part 6: Statement 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.

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:

[Empty text box for name of medical treatment decision maker]

Signature of medical treatment decision maker: Date: (dd/mm/yyyy)

[Empty text boxes for signature and date of medical treatment decision maker]

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

[Empty text box for name of adult witness]

Signature of adult witness: Date: (dd/mm/yyyy)

[Empty text boxes for signature and date of adult witness]

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).