Enduring power of attorney (medical treatment)

This **enduring power of attorney** is given on the

Print date here ____________ day of ____________ , 20 ______ ,

Print your full name here by ____________

Print your address here of ____________

under Section 5A of the *Medical Treatment Act 1988*.

Cross out the following option if you also wish to appoint an alternate agent.

Print the full name of your agent here 1. **I appoint** ____________

Print your agent's address here of ____________

to be my agent.

Or

Cross out the following option if you do not wish to appoint an alternate agent.

Print the full name of your agent here 1. **I appoint** ____________

Print your agent's address here of ____________

to be my agent

Print the full name of your alternate agent here **and** ____________

Print your alternate agent's address here of ____________

to be my alternate agent.

2. I **authorise** my agent or, if applicable, my alternate agent, to make decisions about medical treatment on my behalf.

3. I revoke all other enduring powers of attorney (medical treatment) previously given by me.

Sign your name here **Signed, sealed and delivered by:** ____________

Print your witnesses' names here We ____________

Print your name here each believe that ____________

in making this enduring power of attorney (medical treatment) is of sound mind and understands the import of this document. **Witnessed by:**

Witnesses sign here

	____________	____________
	Person authorised to witness statutory declarations	*Other witness*
Name of witnesses	____________	____________
Addresses of witnesses	____________	____________
	____________	____________