



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.	Your full name:	
	Date of birth: (dd/m	nm/yyyy)
You must fill in your full name, date of birth and address. A phone number is optional.	Address:	
	Phone number:	

Part 2: Medical treatment decision maker details

Full name:

Phone number:

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

Fill in the details of your first medical treatment decision

maker here.

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.

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

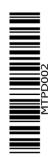
I appoint as my medical treatment decision maker(s):

Medicai	treatment	decision mai	ker 1

Date of birth: (dd/mm/yyyy)

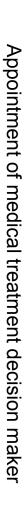
Address.				
Phone number:				
Medical treatment decision maker 2				
Full name:				
Date of birth: (dd/m	m/yyyy)			
Address:				





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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.					
Part 4: Witnessing]				
You must sign in front of two adult witnesses.	Signature of person making this appointmen	nt (you sign here)			
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. Refer to the checklist if someone else is signing on your behalf.	 Each witness certifies that: at the time of signing the document, the person ma appears to have decision-making capacity and appnature and consequences of making the appointment previous appointment; and at the time of signing the document, the person ma appeared to freely and voluntarily sign the document the person signed the document in my presence and second witness; and I am not the person's medical treatment decision mappointment. 	ears to understand the ent and revoking any king this appointment and in the presence of a			
	Witness 1 – Authorised witness				
A registered medical practitioner or someone able to witness affidavits must complete this section.	Full name of authorised witness: Qualification of authorised witness:				
	Signature of authorised witness:	Date: (dd/mm/yyyy)			
	Witness 2 – Adult witness				
Another adult witness must complete this section.	Full name of adult witness:				
	Signature of adult witness:	Date: (dd/mm/yyyy)			





Appointment by:

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(insert your full name)			
If an interpreter is pr	esent when this do	cument is witnessed	t	
If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is	Name of interprete	er:		
	If accredited with t	the National Accredita	tion Autl	nority
	NAATI number:			
witnessed.	I am competent to	interpret from English	into the	e following language:
	I provided a true a of the document.	nd correct interpretati	on to fac	cilitate the witnessing
	Signature of interp	Signature of interpreter:		Date: (dd/mm/yyyy)
Part 5: Interprete	er statement			,
If an interpreter assis		tion of this documen	ıt	
If an interpreter	I interpreted in the following language:			
assisted you in preparing this				
document, the interpreter completes	When I interpreted into this language the person appeared			
this part. Cross out Part 5 if not relevant.	to understand the language used in the document.			
	Name of interpreter:			
	NAATI number (if	accredited):		
	Signature of interp	oreter:		Date: (dd/mm/yyyy)



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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.

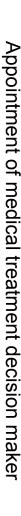
Your first medical treatment decision maker must read this statement of acceptance and sign in front of an adult witness.

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





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Appointment by: (insert your full name)

Medical treatment decision maker 2

Part 6: Statement of acceptance (cont.)

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.		
	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)	

Name of modical tractment decision modern

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).