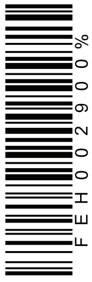


easternhealth

ENDURING POWER OF ATTORNEY (MEDICAL TREATMENT)

Medical Treatment Act 1988 Schedule 2

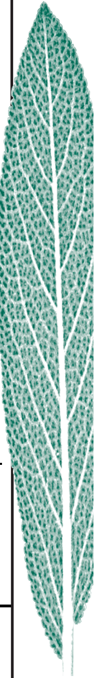
UR Number: ____________

Surname: ____________

Given Name: ____________

Date of Birth: ___/___/___ Sex: M / F

(Affix Hospital I.D. Label if Available)



THIS ENDURING POWER OF ATTORNEY is given on the _________ day of____________ 20____

by ____
(your name)

of ____
(your address)

Under Section 5A of the *Medical Treatment Act* 1988

*Choose either **1(a)** or **1(b)** (cross out whichever does not apply)*

1(a) My Agent

I APPOINT ____
(your agent's name)

of____to be my agent
(your agent's address)

OR

1(b) My Agent and My Alternate Agent

I APPOINT ____
(your agent's name)

of____to be my agent
(your agent's address)

and ____
(your alternate agent's name)

of____ to be my alternate agent.
(your alternate agent's address)

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.

SIGNED, SEALED & DELIVERED BY:____
(your signature)

We ______________________ **and** ______________________
(your witnesses' names)

each believe that ____________ ______________________
(your name)

In making this Enduring Power of Attorney (Medical Treatment) is of sound mind and understands the importance of this document.

WITNESSED BY:

(1) ______________________
(signature of witness)

(2) ______________________
(signature of witness authorised to take statutory declarations)

(1) ______________________
(name of witness)

(2) ______________________
(name and authority of witness)

(1) ______________________
(address of witness)

(2) ______________________
(address of witness)

FSG Print Management Tel: 9873 5144 Fax: 9873 5966

MEDICAL ENDURING POWER OF ATTORNEY EH 002900