BCH
Bass Coast Health

SCHEDULE 3
Enduring Power of Attorney (Medical Treatment)

Medical Treatment Act 1988 Schedule 2

Surname ..... U.R. No.....

Christian Names..... Sex .....

PATIENT LABEL

Date of Birth ...../...../..... Age .....

Doctor ..... Ward.....

PLACE LABEL HERE

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)** and then cross out the one you do not choose)

1 (a)

I APPOINT _____
(Your Agent's Name)

of _____ to be my agent
(Your Agent's Address)

1 (b)

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 AND DELIVERED by: _____
(Your Signature)

We _____ and _____
(your Witnesses' Names)

each believe that _____ in making this
(your Name)

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

WITNESSED BY:

(1) _____
(Signature of Witness authorised to take statutory declarations)

(2) _____
(Signature of Witness)

(1) _____
(Name and authority of Witness)

(2) _____
(Name of Witness)

(1) _____
(Address of Witness)

(2) _____
(Address of Witness)

This is a true and complete copy of the corresponding page of the original.

Signed: _____ Date: ____/_____

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CONTACT INFORMATION / MEPOA

Name: _____

Address: _____

Date of Birth: ____/____/____ Contact No.: _____

Name of Agent/Person Responsible: _____
(circle whichever is appropriate)

Contact No.: Home: _____

Mobile: _____

Work: _____

Relationship: _____

Date: ____/____/____

Name of Alternate Agent/Person Responsible: _____
(circle whichever is appropriate)

Contact No.: Home: _____

Mobile: _____

Work: _____

Relationship: _____

Date: ____/____/____

Advance Care Plan includes the following documents:

Medical enduring Power of Attorney ☐ Yes ☐ No

Refusal of Treatment Certificate ☐ Yes ☐ No

Statement of Health Choices ☐ Yes ☐ No

The original of the Advance Care Plan is held by _____

Certified copies of your Advance Care Plan have been given to:
(Complete as many lines as applicable)

1. _____ 5: _____

2. _____ 6: _____

3. _____ 7: _____

4. _____ 8: _____