

**ENDURING POWER OF ATTORNEY  
(MEDICAL TREATMENT)**

THIS ENDURING POWER OF ATTORNEY is given on the  
.....day of ..... 20.....

(your name) by .....

(your address) of .....

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

(your agent's name) 1. I APPOINT \* .....

(your agent's address) of ..... to be my agent

OR

(your agent's name if you're appointing an alternative agent) I APPOINT\* .....

(your agent's address if you're appointing an alternative agent) of ..... to be my agent

(your alternative agent's name) and .....

(your alternative agent's address) of .....

to be my alternate agent. (\*delete whichever is inapplicable)

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 witnesses' names) We.....

(your name) each believe that .....

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

WITNESSED BY:

(signature of witnesses) (1)..... (2).....

(names of witnesses) (1)..... (2).....

(addresses of witnesses) (1)..... (2).....

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