



ADVANCE CARE APPOINTMENT OF SUPPORT PERSON

made under the *Medical Treatment Planning and Decisions Act 2016* (Vic.)

AFFIX PATIENT LABEL HERE

U.R. NUMBER: _____
 SURNAME: _____
 GIVEN NAME: _____
 DATE OF BIRTH: ____/____/____
 SEX: _____

Your support person can access, or help you to access, health information relevant to your medical treatment.

Your support person does not have the power to make medical treatment decisions on your behalf. Any existing support person appointment previously made by you under the Act will be revoked on making this appointment.

Part 1: Personal details

Before you start, read the checklist of steps with this form. You must fill in your full name, date of birth and address. A phone number is optional.

Your full name:			
Date of birth: (dd/mm/yyyy)			
Address:			
Phone number:			

Part 2: Support person details

I appoint as my support person:

Fill in the details of your support person here. You must fill in their full name, date of birth and address. A phone number is optional.

Full name:			
Date of birth: (dd/mm/yyyy)			
Address:			
Phone number:			



Po Box 317, Cohuna 3568
 Phone: 54 565 300
 Fax: 54 562 627

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U.R. NUMBER: _____
 SURNAME: _____
 GIVEN NAME: _____
 DATE OF BIRTH: ____/____/____
 SEX: _____

Appointment by:
 (insert your full name)

Part 3: Witnessing

You must sign in front of two adult witnesses at the same time.

One witness must be a registered medical practitioner or able to witness affidavits.

See justice.vic.gov.au/affidavit for the list of eligible persons.

Neither witness can be your appointed support person.

Refer to the checklist if someone is signing on your behalf.

Signature of person making this appointment (you sign here)

Each witness certifies that:

- at the time of signing the document, the person making this appointment appears to have decision-making capacity and appears to understand the nature and consequences of making the appointment; and
- at the time of signing the document, the person making this appointment appeared to freely and voluntarily sign the document; and
- the person signed the document in my presence and in the presence of a second witness; and
- I am not the person’s support person under this appointment.

Witness 1 – Authorised witness

Full name of authorised witness:

Qualification of authorised witness:

Signature of authorised witness:

Date: (dd/mm/yyyy)

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Witness 2 – Adult witness

Full name of adult witness:

Signature of adult witness:

Date: (dd/mm/yyyy)

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A registered medical practitioner or someone able to witness affidavits must complete this section.

Another adult witness must complete this section.



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Appointment by: (insert your full name)	
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If an interpreter is present when this document is witnessed

If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.

Name of interpreter:

If accredited with the National Accreditation Authority

NAATI number:	
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I am competent to interpret from English into the following language:

I provided a true and correct interpretation to facilitate the witnessing of the document.

Signature of interpreter:	Date: (dd/mm/yyyy)

Part 4: Interpreter statement

If an interpreter assisted in the preparation of this document

If an interpreter assisted you in preparing this document, the interpreter completes this part.
 Cross out Part 4 if not relevant.

I interpreted in the following language:

When I interpreted into this language the person appeared to understand the language used in the document.

Name of interpreter:

NAATI number (if accredited):	
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Signature of interpreter:	Date: (dd/mm/yyyy)

Appointment of support person



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 GIVEN NAME: _____
 DATE OF BIRTH: ____/____/____
 SEX: _____

Appointment by:
 (insert your full name)

Part 5: Statement of acceptance

The support person you appoint must read the statement of acceptance and sign in front of an adult witness.

Support person

Your support person must read this statement of acceptance and sign in front of an adult witness.

I accept my appointment as support person and state that I understand the role of a support person is to:

- support the person to make, communicate and give effect to the person’s medical treatment decisions; and
- represent the interests of the person in respect of the person’s medical treatment, including when the person does not have decision-making capacity in relation to medical treatment decisions.

Name of support person:

Signature of support person:

Date: (dd/mm/yyyy)

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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)

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You have reached the end of this form.

- Please keep your original ‘Appointment of support person’ form safe and accessible.
- Your ‘Appointment of support person’ form can be uploaded on MyHealth Record.