

ADVANCE HEALTH DIRECTIVE

This form deals with your future health care.

The time may come when you cannot speak for yourself. By completing this form, you can give directions about your medical treatment at such a time.

This document can be used by non-English-speakers if a qualified interpreter/translator reads it to the person in the person's own language and a signed Statement of Interpreter/Translator is attached. Blank statements are available from GoPrint offices, WC Penfold Stationers and most newsagents throughout Queensland.

EXPLANATORY NOTES

Every competent adult has the legal right to accept or refuse any recommended health care. This is relatively easy when people are well and can speak for themselves. Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes—at the very time when many critical decisions need to be made. By completing this Advance Health Directive, you can make your wishes known before this happens.

What is an Advance Health Directive?

An Advance Health Directive is a document that states your wishes or directions regarding your future health care for various medical conditions. It comes into effect *only* if you are unable to make your own decisions.

You may wish your directive to apply at any time when you are unable to decide for yourself, or you may want it to apply only if you are terminally ill.

Can anyone make an Advance Health Directive?

Yes, anyone who is over eighteen years of age and is capable of understanding the nature of their directions and foreseeing the effects of those directions can generally make an Advance Health Directive.

What do I need to consider before making an Advance Health Directive?

You should think clearly about what you would want your medical treatment to achieve if you become ill. For example:

- If treatment could prolong your life, what level of quality of life would be acceptable to you?
- How important is it to you to be able to communicate with family and friends?
- How will you know what technology is available for use in certain conditions?

It is strongly recommended that you discuss this form with your doctor before completing it. In addition, a doctor must complete Section 5 of the form.

The purpose of an Advance Health Directive is to give you confidence that your wishes regarding health care will be carried out if you cannot speak for yourself. However, a request for euthanasia would not be followed, as this would be in breach of the law. Under the Queensland Criminal Code, it is a criminal offence to accelerate the death of a person by an act or omission. It is also an offence to assist another person to commit suicide.

Can I cover all possible health-care decisions in this form?

No, it would not be possible to anticipate everything. However, if you wish, you can give someone enduring power of attorney to make health-care decisions on your behalf.

Note: *This person will not be able to make 'special health' decisions.*

If you have already given someone enduring power of attorney for personal/health matters, all you need to do is discuss this directive with that person and complete Section 6 when you come to it.

If you have **not** yet appointed anyone and you wish to do so, you will need to complete Section 7 of this form when you come to it.

You may also wish to give someone enduring power of attorney for financial matters in case you need someone to manage your property or money, e.g. if you are in a nursing home. If you wish to do that, you will need to complete a separate enduring power of attorney form.

Can I change or revoke my Advance Health Directive?

Yes, your wishes as stated in an Advance Health Directive are not final; you can change them at any time while you remain mentally capable of doing so.

It is wise to review your directive every two years or if your health changes significantly.

If you do want to make changes to your directive, you should destroy the current one and make a new one.

You may also totally revoke your directive at any time. This must be done in writing, but no specific form is required and the person witnessing your signature does **not** need to be a justice of the peace, commissioner for declarations, lawyer or notary public.

Where can I get help with my Advance Health Directive?

As your doctor must complete Section 5 of this document, you could ask him/her to help you. Your doctor could explain any medical terms or other words that you are unclear about. You may also wish to discuss your decisions with family members or close friends.

Who is involved in completing this document?

At least three people:

You, as the principal. (You are referred to as the principal because you are the person principally involved.) You complete Sections 1 to 4, Section 6 or Section 7 if you wish, and Section 8.

A doctor must complete Section 5.

Your witness must complete Section 9. Your witness must be twenty-one years of age or over and must be a justice of the peace, a commissioner for declarations, a lawyer or a notary public. He/she must not be your attorney, a relation of yours or of your attorney, a beneficiary under your will, your current paid carer or your current health-care provider (e.g. nurse or doctor). Your witness and the doctor who signs Section 5 do not have to sign the document on the same date.

Note:

'Paid carer' does not mean someone receiving a carer's pension or similar benefit, so you are free to choose someone who is receiving such a benefit for looking after you.

If you use this form to appoint someone as your attorney for personal/health matters, you will have to complete Section 7 and the person you appoint will have to complete Section 10.

You may wish to discuss the document with your solicitor. However, this is not a requirement.

What do I do with the completed document?

You should keep it in a safe place, and you should give a copy to your own doctor, to your attorney for personal/health matters if you have appointed one, to a family member or friend and, if you wish, to your solicitor.

If you are admitted to hospital, make sure the hospital staff know that you have an Advance Health Directive and where a copy can be obtained.

You may also wish to carry a card in your purse or wallet stating that you have made a directive, and where it can be found.

How often should I update my Advance Health Directive?

It is strongly recommended that you review the document every two years, or if/when there is a major change in your health status (e.g. if you are diagnosed with a serious illness). If you do not wish to make any changes, simply sign and date one part of Section 11. If you do want to make major changes, you will need to complete a new document.

SECTION 1: Your details

It is strongly recommended that, before completing this document, you discuss it with your general practitioner or a specialist medical practitioner who knows your medical history and views. The doctor will then be able to explain any medical terms that you are unsure about and will also be able to state that you were not suffering from depression or any other condition that would affect your ability to understand the decisions you have made in the document. You can then ask this doctor to be present when you sign the document.

Complete this section by writing on the lines.

TO MY FAMILY, FRIENDS AND HEALTH-CARE PROVIDERS

1. I, _____ ,
[Print your full name here]
- of _____ ,
[Print here the number of your house, name of your street and suburb]
- State: _____ Postcode: _____ ,
[Print here the name of the State where you live]
- born on _____ ,
[Print here the date of your birth]

being over the age of eighteen years, make this directive after careful consideration and of my own free will.

If at any time I am unable to take part in decisions about my medical care, let this document stand as evidence of my views, wishes and beliefs about my quality of life and the medical treatment I require.

This directive should never be used if I have the capacity to speak competently for myself or if there is evidence that it has been revoked.

I sign this document in the full knowledge that my health care may be limited as a result, but only as specified below.

I request that all who are responsible for my care respect the directions given in this document.

SECTION 2: General instructions

(Complete this section by ticking the appropriate boxes and writing on the lines.)

- 2. If I temporarily lose capacity and am unable to give directions for my health care because of injury or illness, I want my health-care providers to give me:**

- ☐ all available treatment
☐ all available treatment except for: _____

[Write here any treatment you would not want to have in any circumstances]

- 3. Are there any special conditions that your health-care providers should know about, such as asthma or any allergy to medication?**

- ☐ No ➔ Go to 5.
☐ Yes.

- 4. Describe these special conditions here (for example 'I develop a severe rash when given penicillin' or 'I have insulin-dependent diabetes'):**

[Use these lines to write descriptions of any special conditions]

- 5. Do you have any religious beliefs that may affect your treatment?**

- ☐ No ➔ Go to Section 3.
☐ Yes.

- 6. Describe here how your religious beliefs might affect your treatment (for example: 'Because of my religious beliefs, I do not want to receive any blood transfusions or organ transplants'):**

[Use these lines to describe how your religious beliefs might affect your medical treatment]

SECTION 3: Terminal, incurable, or irreversible conditions

Definitions of terms used in this section

- **terminal:** *resulting in death—the patient can reasonably be expected to die within the next twelve months, and this prognosis has been confirmed by a second medical practitioner.*
- **incurable:** *no known cure.*
- **irreversible:** *unable to be turned around—there is no possibility that the patient will recover. An example of an irreversible illness is Motor Neurone Disease, which progressively paralyses the body.*
- **permanent unconsciousness (coma):** *when brain damage is so severe that there is little or no possibility that the patient will regain consciousness.*
- **persistent vegetative state:** *severe and irreversible brain damage, but vital functions of the body continue (e.g. heart beat and breathing).*
- **palliative care:** *treatment that is not aimed at a cure but at caring for the patient by keeping him/her as physically comfortable and pain-free as possible, while also attending to his/her emotional, mental, social and spiritual needs.*

Life-sustaining measures

These include:

- **cardiopulmonary resuscitation:** *emergency measures to keep the heart pumping (by massaging chest or using electrical stimulation) and artificial ventilation (mouth-to-mouth or ventilator) when breathing and heart beat have stopped.*
- **assisted ventilation:** *use of a machine, such as a ventilator, to help the patient breathe when he/she is unable to breathe unaided.*
- **artificial feeding and hydration:** *provision of food and fluid by artificial means when the patient is unable to eat or drink. This may be done by passing a tube through the nose into the stomach or by inserting a tube into a vein or directly into the stomach. (If you do not have artificial feeding, your mouth will still be kept moist.)*

If you are extremely ill, you may be treated by someone who is not your usual doctor. This person is referred to as **your treating medical practitioner**.

The directions you give in this section apply *only* if, in the opinion of your treating medical practitioner:

- *you have a terminal, incurable, or irreversible illness or condition,*
- *or you are in a persistent vegetative state,*
- *or you are permanently unconscious,*
- *or you are so seriously ill or injured that you are unlikely to recover to the extent that you can survive without the continued use of life-sustaining measures.*

Complete this section by:

- *first considering the points carefully,*
- *then ticking the boxes next to the points that you want to apply to you,*
- *then writing your initials on the lines that follow those points,*
- *and finally, drawing a line across any part that you do not want to apply to you.*

7. I request that:

- ☐ everyone responsible for my care initiate *only* those measures that are considered necessary to maintain my comfort and dignity, with particular emphasis on the relief of pain.

[Initial here]

- ☐ any treatment that might obstruct my natural dying either not be initiated or be stopped.

[Initial here]

- ☐ unless required for my dignity and comfort as part of my palliative care, no surgical operation is to be performed on me.

[Initial here]

8. If I am in the terminal phase of an incurable illness:

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:* _____
☐ I **do** want cardiopulmonary resuscitation. *Initial here:* _____

☐ I **do not** want assisted ventilation. *Initial here:* _____
☐ I **do** want assisted ventilation. *Initial here:* _____

☐ I **do not** want artificial hydration. *Initial here:* _____
☐ I **do** want artificial hydration. *Initial here:* _____

☐ I **do not** want artificial nutrition. *Initial here:* _____
☐ I **do** want artificial nutrition. *Initial here:* _____

☐ I **do not** want antibiotics. *Initial here:* _____
☐ I **do** want antibiotics. *Initial here:* _____

Other treatment (specify):

☐ I **do not** want _____ *Initial here:* _____
☐ I **do** want _____ *Initial here:* _____

9. If I am permanently unconscious (in a coma):

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:* _____
☐ I **do** want cardiopulmonary resuscitation. *Initial here:* _____

☐ I **do not** want assisted ventilation. *Initial here:* _____
☐ I **do** want assisted ventilation. *Initial here:* _____

☐ I **do not** want artificial hydration. *Initial here:* _____
☐ I **do** want artificial hydration. *Initial here:* _____

☐ I **do not** want artificial nutrition. *Initial here:* _____
☐ I **do** want artificial nutrition. *Initial here:* _____

☐ I **do not** want antibiotics. *Initial here:* _____
☐ I **do** want antibiotics. *Initial here:* _____

Other treatment (specify):

☐ I **do not** want _____ *Initial here:* _____
☐ I **do** want _____ *Initial here:* _____

10. If I am in a persistent vegetative state:

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:* _____
☐ I **do** want cardiopulmonary resuscitation. *Initial here:* _____

☐ I **do not** want assisted ventilation. *Initial here:* _____
☐ I **do** want assisted ventilation. *Initial here:* _____

☐ I **do not** want artificial hydration. *Initial here:* _____
☐ I **do** want artificial hydration. *Initial here:* _____

☐ I **do not** want artificial nutrition. *Initial here:* _____
☐ I **do** want artificial nutrition. *Initial here:* _____

☐ I **do not** want antibiotics. *Initial here:* _____
☐ I **do** want antibiotics. *Initial here:* _____

Other treatment (specify):

☐ I **do not** want _____ *Initial here:* _____
☐ I **do** want _____ *Initial here:* _____

11. If I am so seriously ill or injured that I am unlikely to recover to the extent that I can live without the use of life-sustaining measures:

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:* _____
☐ I **do** want cardiopulmonary resuscitation. *Initial here:* _____

☐ I **do not** want assisted ventilation. *Initial here:* _____
☐ I **do** want assisted ventilation. *Initial here:* _____

☐ I **do not** want artificial hydration. *Initial here:* _____
☐ I **do** want artificial hydration. *Initial here:* _____

☐ I **do not** want artificial nutrition. *Initial here:* _____
☐ I **do** want artificial nutrition. *Initial here:* _____

☐ I **do not** want antibiotics. *Initial here:* _____
☐ I **do** want antibiotics. *Initial here:* _____

Other treatment (specify):

☐ I **do not** want _____ *Initial here:* _____
☐ I **do** want _____ *Initial here:* _____

Tissue donation*

You may use this form to authorise tissue donations for purposes referred to in section 22(1) and section 23(1) of the *Transplantation and Anatomy Act 1979*. These purposes are the transplantation of the tissue to the body of a living person or the use of the tissue for other therapeutic purposes or for other medical or scientific purposes.

12. Do you consent to the removal of tissue after death?

☐

No ➡ *Go to section 4.*

☐

Yes.

13. I agree that, if necessary for tissue donation, life support systems such as assisted ventilation may be continued. In all other circumstances, my wishes as listed in clauses 7-11 are to be respected.

[Initial here]

***Note:** *Tissue donation includes organ donation.*

SECTION 4: Personal statement

If you have any specific views about particular types of health care or special health matters that have not already been covered in this directive, you can record them in this section. It is recommended that you discuss this section with your doctor before completing it, as it is important that anything you write should be readily understood by medical staff who are treating you.

It is your legal right to refuse any medical treatment. However, you may not be entitled to insist on receiving a particular treatment (if, for example, your health-care provider's professional opinion is that the treatment would not be of benefit to you).

- 14. Do you have any particular wishes about health care or special health matters other than those listed in Sections 2 and 3?**

- ☐ No ➡ Go to 16.
☐ Yes.

- 15. Record your wishes here.** (For example, you may wish to write something similar to the following: 'I value life, but not under all conditions. I consider dignity and quality of life to be more important than mere existence' or 'I request that I be given sufficient medication to control my pain, even if this hastens my death'.)

- 16. Do you wish to mention any people who are *not* to be contacted about your treatment?**

- ☐ No ➡ Go to Section 5.
☐ Yes.

- 17. List here the names of any people who are not to be contacted about your treatment:**

SECTION 5: Doctor involvement

It is a requirement of the Powers of Attorney Act 1998 that you sign this document in the presence of a doctor. It is strongly recommended that, before completing this document, you discuss it with your general practitioner or a specialist medical practitioner who knows your medical history and views. The doctor will then be able to explain any medical terms that you are unsure about and will also be able to state that you were not suffering from depression or any other condition that would affect your ability to understand the decisions you have made in the document. In addition to the doctor signing this section, an independent witness must sign Section 9—this does not have to be on the same day.

18. Doctor's name: _____

Doctor's address: _____

_____ Postcode: _____

Doctor's telephone number: _____

19. Statement of nominated doctor

(a) I have discussed this document with the principal and, in my opinion, he/she is not suffering from any condition that would affect his/her capacity to understand the things necessary to make this directive, and he/she understands the nature and likely effect of the health care described in this document, and

(b) *(tick one box only)*

☐

the principal signed this part of this document in my presence,

☐

in my presence, the principal instructed another person to sign this part of this for the principal, and the person signed it in my presence and in the presence of the principal,

(c) I am not

- the person witnessing this Advance Health Directive (Section 9)
- or the person signing the Advance Health Directive for the principal
- or an attorney of the principal
- or a relation of the principal or of an attorney of the principal
- or a beneficiary under the principal's will.

[Principal signs here]

[Doctor signs here]

[Doctor writes the date here]

20. If this directive is ever required for your medical care, do you want the doctor named above (Clause 18) to be consulted by your treating medical practitioner?

☐

Yes.

☐

No.

SECTION 6: Enduring power of attorney for personal/health matters

If you have appointed someone as your attorney for personal/health matters, you can use this section to direct him/her to make decisions on your behalf about what health care is to be used in situations that are not dealt with explicitly in this form (except for 'special health' matters).

It is important to discuss with your attorney/s your views and wishes regarding your health care as you have set them down in this directive so that any decisions he/she/they may make on your behalf will accord with your wishes.

Note: Only enduring powers of attorney for personal/health matters made since the Powers of Attorney Act 1998 was proclaimed are valid. Powers of attorney for **financial** matters made before that date may be valid.

21. Have you completed the document called 'Enduring Power of Attorney' (short form or long form)?

- ☐ No ➡ Go to Section 7.
☐ Yes.

22. In the Enduring Power of Attorney document, did you appoint an attorney for personal/health matters?

- ☐ No ➡ Go to Section 7.
☐ Yes.

23. Print your attorney's name, address and telephone number here:

Attorney's name: _____

Attorney's address: _____

Attorney's telephone number: (work) _____ (home) _____

24. Did you appoint more than one attorney for personal/health matters?

- ☐ No ➡ Go to 26.
☐ Yes. Print the name/s, address/es and telephone number/s of your other attorney/s here:

Second attorney's name: _____

Second attorney's address: _____

Second attorney's telephone number: (work) _____ (home) _____

Third attorney's name: _____

[If you do not have a third attorney, cross these lines out]

Third attorney's address: _____

Third attorney's telephone number: (work) _____ (home) _____

25. How do you prefer that your attorneys make their decisions? (Tick one box only)

☐

Severally (any one of them may decide)

☐

Jointly (unanimously)

☐

As a majority (if you are appointing more than three attorneys, please specify, e.g. 'Simple majority', 'Two-thirds majority'):

☐

Other*

Note: *The Powers of Attorney Act 1998 allows you to appoint successive attorney/s for a matter so that the power is given to a particular attorney only when power to a previous attorney ends. You can nominate the circumstances that a power will end (e.g. if x leaves the jurisdiction y may act).*

26. If I lose the capacity to make health-care decisions for myself and the directions in this Advance Health Directive are inadequate for any reason, I authorise my attorney/s to make decisions about health matters for me.

[Principal signs here]

27. I understand that an attorney for personal/health matters can make decisions about health matters for me. I also understand that the *Powers of Attorney Act 1998* the *Guardianship and Administration Act 2000* does **not allow an attorney to decide special health matters—donation of body tissue, sterilisation, termination of pregnancy, research or experimental care, certain psychiatric or other health matters specified in the regulations.**

[Principal signs here]

➡ **Go to Section 8.**

SECTION 7: Appointing an attorney for personal/health matters

If you have already appointed an attorney for personal/health matters, you do not need to complete this section.

(Note: If you have already appointed an attorney for personal/health matters and you appoint another person here, this appointment will cancel out the previous one.)

Complete this form by writing on the lines and ticking the appropriate boxes.

28. Do you wish to appoint an attorney for personal/health matters?

☐ No ➡ *Go to Section 8.*

☐ Yes.

Note: The person/s you appoint must be over the age of eighteen and must not be your current paid carer or health-care provider.

29. I, _____ ,
[Print your full name here]
of _____ ,
[Print your address here]
appoint _____ ,
[Print the full name of your first attorney here]
of _____
[Print your first attorney's address here]
_____ Ph: _____ ,

and _____ ,
[Print the full name of your second attorney if you wish to appoint more than one
OR rule a line through this and the next 5 lines if you wish to appoint only one]
of _____
[Print here the address of your second attorney]
_____ Ph: _____

and _____
[Print here the full name of your third attorney if you wish to appoint three
OR rule a line through this line and the next 2 lines if you wish to appoint only two attorneys]
of _____
[Print here the address of your third attorney]
_____ Ph: _____
as my attorney/s for personal matters.

30. Do you want to set any terms for the power given in Clause 29 (e.g. limit the power of your attorney or give specific information about your wishes)?

☐ No ➡ *Go to 32.*

☐ Yes.

31. Write these terms here: *(For example: 'My attorney/s must not consent to a blood transfusion on my behalf' or 'If I need nursing-home care, I want my attorney to try XYZ Nursing Home first'. Do not include any instructions here about withdrawing or withholding life-sustaining medical treatment. These instructions can only be given by you in Section 3 of this form.)*

32. Are you appointing more than one attorney for personal/health matters?

- ☐ No ➔ Go to 34.
☐ Yes.

33. How do you prefer that they make their decisions? *(Tick one box only)*

- ☐ Severally (any one of them may decide)
☐ Jointly (unanimously)
☐ As a majority (if you are appointing more than three attorneys, please specify, e.g. 'Simple majority', 'Two-thirds majority'):

- ☐ Other*

***Note:** *The Powers of Attorney Act 1998 allows you to appoint successive attorney/s for a matter so that the power is given to a particular attorney only when power to a previous attorney ends. You can nominate the circumstances that a power will end (e.g. if x leaves the jurisdiction y may act).*

34. Statement of understanding

- (1) I fully understand that, by signing this section, I give power to the attorney/s mentioned in Clause 29 to make decisions on my behalf about personal/health matters, including health-care decisions.
- (2) I understand that I may specify or limit the attorney/s power, and instruct the attorney/s about the exercise of the power.
- (3) I understand that this gives my attorney/s power to do, for me, anything I could lawfully do myself in relation to these matters (except for special personal/health matters), subject to any terms mentioned in Clause 31.
- (4) I understand that my attorney/s power to make decisions about health matters on my behalf does not begin unless/until I lose the capacity to make such decisions myself.
- (5) I understand that I may change or revoke this enduring power of attorney at any time so long as my power to make such a decision is not impaired or, in other words, so long as I am capable of making another enduring power of attorney.

[Principal signs here]

SECTION 8: Statement of understanding and signature

This statement declares that you fully understand the directives you have given. Read through it carefully, and then sign on the line that follows.

You must sign the document in front of a qualified witness—that is, someone who is a justice of the peace, a commissioner for declarations, a lawyer or a notary public. The witness must be twenty-one years or over and not your attorney, a relation of yours or of your attorney, your current paid carer or your current health-care provider.

Note: 'Paid carer' does not mean someone receiving a carer's pension or similar benefit.

If you are not physically able to sign for yourself, you may have another person sign the document on your behalf, but you must be in the presence of the witness when you instruct that person to sign for you and when he/she actually signs. He/she must be at least eighteen years old and must not be the witness to this document or your attorney. Any person who signs on your behalf should print his/her name and designation (e.g. nurse, doctor, neighbour, daughter) in the space indicated, tick the boxes, and then sign the statement with his/her own signature.

35. I understand:

- the nature and the likely effects of each direction stated in this directive;
- that a direction operates only while I have impaired capacity for the matter covered by the direction;
- that I may change or revoke a direction in the directive at any time where I have the capacity to make a decision about the matter covered by the direction;
- that at any time I am not capable of revoking a direction in the directive, I am unable to effectively oversee the implementation of the directive.

[Principal signs here]

or

If you are signing for principal:

[Witness signs here]

I, _____, state that:

[print your full name here]

- (a) I am at least eighteen years old
- (b) I am not a witness for this enduring directive or an attorney for the principal.

[Witness writes the date here]

[Person signing for the principal signs here]

[Write the date here]

SECTION 9: Witness's certificate

IMPORTANT NOTICE TO THE WITNESS

Your role goes beyond ensuring that the signature of the principal (the person making the directive) is genuine. You certify that the principal appeared to understand the matters stated in Clause 35 (and Clause 34 if applicable). In the future, you may have to provide information about the principal's capacity to understand these matters when making the directive. If you are doubtful about the principal's capacity, you should make the appropriate inquiries, e.g. from the principal's doctor.

It is strongly recommended that, if you are in any doubt, you make a written record of the proceedings and of any questions you asked to determine the principal's capacity.

As witness, you complete this section by writing on the lines and ticking the appropriate boxes.

36. I, _____, state that—

[Print your full name here]

(a) I am at least 21 years of age,

(b) I am a

☐

justice of the peace

☐

commissioner for declarations

☐

lawyer

☐

notary public,

(c) I am not

☐

an attorney for the principal

☐

or a relation of the principal, or a relation of the principal's attorney (if any)

☐

or a beneficiary under the principal's will

☐

or a current paid carer or health-care provider for the principal,

Note:

'Paid carer' does not mean someone receiving a carer's pension or similar benefit.

(d) I have verified that Section 5 of this document has been signed and dated by a doctor.

(e) *(Tick one box only)*

☐

the principal signed this directive in my presence

☐

in my presence, the principal instructed another person to sign for the principal, and the person signed it in my presence and in the presence of the principal,

and

(f) at the time that this directive was signed, the principal appeared to me to understand the matters stated in clause 35 (and clause 34 if applicable).

[Witness signs here]

SECTION 10: Attorney's acceptance

This section is completed only if an attorney was appointed in Section 7. If no attorney was appointed in Section 7, rule a line through the whole section.

As attorney, you complete the section of this form that applies to you by ticking the boxes and writing on the lines. If you are not able to tick all the boxes truthfully, then you must not accept this appointment as attorney.

37. **The first attorney completes this part:**

I, _____, state that:

[Print your full name here]

- ☐ I am eighteen or over,
- ☐ I am not a current paid carer of the principal,
- ☐ I am not a current health-care provider for the principal,
- ☐ I have read Section 7, giving me enduring power of attorney for personal/health matters,
- ☐ I understand that, by signing this document, I take on the responsibility of exercising the power I have been given in Section 7,
- ☐ I also understand that I must exercise the power in accordance with the *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000*.

[First attorney signs here]

[Write the date here]

The second attorney, if any, completes this part:

I, _____, state that:

[Print your full name here]

- ☐ I am eighteen or over,
- ☐ I am not a current paid carer of the principal,
- ☐ I am not a current health-care provider for the principal,
- ☐ I have read Section 7, giving me enduring power of attorney for personal/health matters,
- ☐ I understand that, by signing this document, I take on the responsibility of exercising the power I have been given in Section 7,
- ☐ I also understand that I must exercise the power in accordance with the *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000*.

[Second attorney signs here]

[Write the date here]

The third attorney, if any, completes this part:

I, _____, state that:

[Print your full name here]

- ☐ I am eighteen or over,
- ☐ I am not a current paid carer of the principal,
- ☐ I am not a current health-care provider for the principal,
- ☐ I have read Section 7, giving me enduring power of attorney for personal/health matters,
- ☐ I understand that, by signing this document, I take on the responsibility of exercising the power I have been given in Section 7,
- ☐ I also understand that I must exercise the power in accordance with the *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000*.

[Third attorney signs here]

[Write the date here]

Section 11: Review of this document

It is strongly recommended that you regularly review this document, as your wishes may change or there may be advances in medical technology. You would be wise to review the document every two years or if the state of your health changes significantly.

Each time you review your document and your wishes have not changed, sign and date one of the acknowledgments below. If your wishes have changed a great deal, you should complete a new document.

REVIEW OF DOCUMENT: 1

I affirm that I have reviewed this document and that there is nothing I would like to change.

Signature: _____ Date: _____

REVIEW OF DOCUMENT: 2

I affirm that I have reviewed this document and that there is nothing I would like to change.

Signature: _____ Date: _____

REVIEW OF DOCUMENT: 3

I affirm that I have reviewed this document and that there is nothing I would like to change.

Signature: _____ Date: _____



QUEENSLAND GOVERNMENT

January 2004