

**ENDURING POWER OF ATTORNEY**

THIS ENDURING POWER OF ATTORNEY is made on the \_\_\_\_\_ day of \_\_\_\_\_ in the State of Victoria, pursuant of Section 114 of the Instruments Act 1958.

- 1. I APPOINT \_\_\_\_\_ of \_\_\_\_\_ in the State of \_\_\_\_\_ to Victoria to be my attorney.
- 2. I AUTHORIZE my attorney to do anything that I may lawfully authorise an attorney to do.
- 3. I DECLARE that that this power of attorney shall continue to operate, and have full force and effect notwithstanding that I may subsequently become incapable.

SIGNED SEALED AND DELIVERED BY: -----

WITNESSED BY:

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(signature of witness)

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(signature of witness)

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(name of witness)

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(name of witness)

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(address of witness)

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(address of witness)

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

THIS ENDURING POWER OF ATTORNEY is given on the \_\_\_\_\_ day of \_\_\_\_\_ in the State of \_\_\_\_\_ 2003, by \_\_\_\_\_ of \_\_\_\_\_ Victoria, under Section 5A of the Medical Treatment Act 1988.

- 1. I APPOINT \_\_\_\_\_ of \_\_\_\_\_ in the State of \_\_\_\_\_ Victoria to be my agent.
- 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:

We, \_\_\_\_\_ each believe that in making this enduring power of attorney (medical treatment) is of sound mind and understands the import of this document.

WITNESSED BY:

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(signature of witness)

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(signature of witness)

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(name of witness)

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(name of witness)

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(address of witness)

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(address of witness)