RECORD OF ORAL REVOCATION OF ADVANCE DIRECTIVE

Section I: Personal details of the maker of oral revocation

Name: *(Note: Please use capital letters)*

Identity document No.:

Gender: Male / Female

Date of birth: _____ /_____ / _____

(Day) (Month) (Year)

Contact Address:

Home Telephone No.:

Office Telephone No.:

Mobile phone No.:

Section II: Witness

Statement of Witness

(Note: This witness must be at least 18 years of age)

(1) I, _____ *(please print name)* sign below as a witness.

(2) I confirm that _____ *(please print name)* has, on _____ *(date of revocation)* at _____am/pm, in my presence, orally revoked all previous advance directives relating to his/her medical care and treatment.

(3) I am not related to _____ ***(please print name)*** by blood, marriage or adoption, nor to the best of my knowledge, am I a beneficiary

under his/her will or any policy of insurance held by him/her or any other instrument made by him/her or on his/her behalf.

_____ _____

(Signature of witness) **(Date)**

Name:

Occupation:

Identity document No. / Medical Council Registration No.:

Home address / Contact address:

Home Tel. No. / Contact No.: