

FORM 3

NOTICE OF REVOCATION OF ADVANCE MEDICAL DIRECTIVE

ADVANCE MEDICAL DIRECTIVE ACT [CHAPTER 4A, SECTION 7(1) AND (3)]

ADVANCE MEDICAL DIRECTIVE REGULATIONS

INSTRUCTIONS

1. Any person who has made an advance medical directive under the Advance Medical Directive Act may in the presence of at least one witness revoke the directive in writing, orally, or in any other way in which the person can communicate.
2. It is the duty of the person revoking the directive (if practicable) and each witness of such a revocation to notify the Registrar of Advance Medical Directives of the revocation. The notice of revocation may be made in this form, or other ways of writing provided that the particulars of the name, address and telephone number of the person revoking the directive and of the witness, and the date, time and place where the revocation was made, are included. The Registrar will send an acknowledgment to the person revoking the directive when the notice of revocation is received.
3. Please send this form by fax or other means immediately after it is completed to the address given below. If the form is faxed, the original copy should also be forwarded to the Registry.

The Registry of Advance Medical Directives

Ministry of Health, College of Medicine Building, 16 College Road, Singapore 169854
Tel: 63259136 Fax: 63259212

(Please direct all enquiries to this address)

REVOCATION OF ADVANCE MEDICAL DIRECTIVE

1. This notice indicates the revocation made by the person named below of his advance medical directive registered under the Advance Medical Directive Act, in the presence of the witness named below.

Revocation Details: Date: Time: Place: _____

2. The revocation was made by the person (please tick one of the following boxes) -

☐ in *writing* in the presence of the witness named below.

- This form can serve as the written revocation as well as the notice of revocation.
- If the revocation is written on a separate sheet of paper and this form is used as the notice of revocation, please append that sheet of paper to this form.

☐ by *non-written way of communication* in the presence of the witness named below.

- This form will serve as the notice of revocation.
- Please specify the way of communication (e.g. orally, sign language, etc.):

PERSON REVOKING ADVANCE MEDICAL DIRECTIVE

Name: _____ NRIC No.: _____

Address: _____

_____ Singapore _____

Home Telephone: _____ Office Telephone: _____

Signature (if practicable)

Date

WITNESS

Name: _____ NRIC No.: _____

Address: _____

_____ Singapore _____

Home Telephone: _____ Office Telephone: _____

Signature

Date