Medical Administration
The Central Data Bank of Advance Medical Directives

Appendix 3

Instructions to Extend the Validity Of Advanced Medical Directives Or Surrogacy Appointment

(Paragraphs 34,39)

I, the undersigned, _____, ID. No. _____, year of birth_____, address_____
being competent as defined by The Dying Patient Law, 2005 (hereafter — The Dying Patient Law), hereby extend the validity of:

[Check one or more of the following options]

☐ The advance medical directives issued by me on (date) _____

☐ The Surrogacy Appointment issued by me on (date) _____

☐ The combined advance medical directives and Surrogacy Appointment issued by me on (date) _____

[Check one of the following options]

☐ For a further five years

☐ For a period not exceeding five years, namely until: _____
[**A date maybe specified here not more than five years from the expiry date of the previous advance medical directives/ Surrogacy Appointment.]**

Signature of Issuer*

I sign this document after deap and careful consideration and of my own free and autonomous will, and not in consequence of any familial, social or other pressure.

Signature: _____ Tel. no. (landline): _____
Tel. no. (mobile):_____ Date: _____

* **Should the issuer of this extention form not speak or read Hebrew, please attach a written authorization of the person who translated for him/her the explanations and directives in the document**

Signature of Witnesses

(The 2 witnesses must sign in each other's presence)

We, the undersigned, witness that the above signatory of this document –

☐ Is personally known to us

☐ Identified himself/herself to us by means of an identifying document which included a photo of the signatory

[Check one of the two above boxes]

- Signed this document in our presence and that he/she appears to us fully aware and speaking to the point, and that there is no sign of any pressure brought to bear on him/her.
- Further: I declare that I do not hold the signatory's surrogacy appointment, nor am I a candidate to do so, nor do I have any economic or other interests involving the signatory.

(A witness may not be one that has economic or other interests involving the signatory, including a family member who has economic or other such interests` However, a doctor or a nurse may be witnesses)

Witness: Name: _____ ID. no. _____
Address:_____
Tel. no. (landline): _____Tel. no. (mobile):_____
Signature: _____ Date: _____

Witness: Name: _____ ID. no. _____
Address:_____
Tel. no. (landline): _____Tel. no. (mobile):_____
Signature: _____ Date: _____

The Central Data Bank of Advance Medical Directives
Ministry of Health
39 Yirmiyahu St., Jerusalem 9446724
maagar.meida@moh.health.gov.il
Tel: *5400 **Fax:** 02-5655916

קול הבריאות *5400

המרכז להנחיות רפואיות מקדימות
משרד הבריאות
רח' ירמיהו 39, ירושלים 446724
maagar.meida@moh.health.gov.il
טל: *5400 **פקס:** 02-5655916

MINISTRY OF HEALTH
For a healthier life

Medical Administration
The Central Data Bank of Advance Medical Directives

3rd Supplement-Extension

Before you send…

To avoid common mistakes while filling out Extension of Advance Medical Directives Form and / or Power of Attorney, and to save unnecessary correspondence to correct the deficiencies, please check the following before sending the form.

☐ P. 1	- You must specify your current residential address in accordance with your registration at the Population Registry. If you wish you may also specify additional mailing address. - You must select and mark the appropriate option: Did you provide Advance Medical Directives Form or Power of Attorney 5 Years ago, or did you fill out both of them. - At the bottom of the page you must sign and date. It is recommended to add a phone No. for clarifications if needed.
☐ P. 2	- At the top of the page there are two empty boxes (☐) in which the witnesses must indicate how they know you. - The form MUST be signed by two witnesses, who are **NOT** first-degree relatives. The witnesses and you must sign on at the same time and in the same place, therefor the date of your signature **MUST** be the same as the date of the witnesses' signature. - A witness is not permitted to be serve as the agent holding the Power of Attorney (and vice versa).
☐	Please send the form by **registered mail** to the following address: Ministry of Health The Central Data Bank of Advance Medical Directives Yirmiyahu St. 39 Jerusalem 9446724

The Central Data Bank of Advance Medical Directives
Ministry of Health
39 Yirmiyahu St., Jerusalem 9446724
maagar.meida@moh.health.gov.il
Tel: *5400 **Fax:** 02-5655916

קול הבריאות *5400

המרכז להנחיות רפואיות מקדימות
משרד הבריאות
רח' ירמיהו 39, ירושלים 446724
maagar.meida@moh.health.gov.il
טל: *5400 **פקס:** 02-5655916