MINISTRY OF HEALTH
For a healthier life

Medical Administration
The Central Data Bank of Advance Medical Directives

Appendix 4

Instructions to Cancel Advance Medical Directives or A Surrogacy Appointment

(Paragraphs 33, 38, 43)

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 cancel:

[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) _____

Signature of Issuer[1]

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

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

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]

[1] **Should the issuer of this cancellation 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**

- 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 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

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4rd Supplement–Cancellation of Advance Medical Directives and / or Power of Attorney

Before you send…

To avoid common mistakes while filling out Cancellation of Advance Medical Directives and / or Power of Attorney form, 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 options and mark: do you wish to revoke the Advance Medical Directives, the Power of Attorney or both. - At the bottom of the page you must sign and specify the 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

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קול הבריאות *5400

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