

I, _____, make this Personal Directive.
Name of Maker

This Personal Directive is made pursuant to the Personal Directives Act and takes effect if I am not capable of making a decision regarding my personal care.

I have placed my initials and my witness has placed his/her initials next to the sections in this document that I want to be part of my Personal Directive.

1. Consultation when assessing capacity (optional)

Witness' Your
Initials Initials

The person making the assessment of my capacity is to consult with the following person when making the assessment.

Name: _____
Print Name, Title or Position of Individual

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

2. Revoking (Cancelling) Other Directions (optional)

Witness' Your
Initials Initials

I revoke (cancel) all previous instructions, personal directives, and authorizations, including those made pursuant to the Medical Consent Act.

OR

Witness' Your
Initials Initials

I revoke (cancel) only the following instructions, personal directives or authorizations:

Date: _____

Description:

3. Authorization to Act as Delegate (optional)

Witness' Your
Initials Initials

I authorize the following person to act as my delegate to make personal care decisions on my behalf for all personal matters, of a non-financial nature, that relate to me.

Name: _____
Print Name of Delegate

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

If my delegate is unable, unwilling or unavailable to make a personal care decision, I authorize the following person to act as my alternate delegate.

Name: _____
Print Name of Alternate Delegate

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

OR

Witness' Your
Initials Initials

I want to authorize more than one delegate to make different personal care decisions on my behalf. I authorize the following individuals to act as my delegates and alternate delegates (if the delegate is unable, unwilling or unavailable to make a personal care decision) to make personal care decisions on my behalf for all the following personal care matters, of a non-financial nature, that relate to me:

health care

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

home care services

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

accommodation,
including placement
in a continuing-care
home

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

with whom I may
live and associate

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

participation in
social activities

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

participation in
educational activities

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

participation in
employment activities

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

other personal care
matters as follows:

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

4. No Delegate Authorized (optional)

I **DO NOT** wish to authorize a delegate, but have provided instructions in section 5
for persons who intend to provide personal care services to me.

Witness'
Initials

Your
Initials

5. Specific Instructions (optional)

I instruct my delegate(s) to carry out the following specific instructions when
making decisions about my personal care:

additional page attached? ☐ Yes ☐ No

Witness' Initials Your Initials

If I have not designated a delegate(s), or if my delegate(s) and alternate delegate(s) are unable, unwilling or unavailable to make a personal care decision, I instruct all persons who intend to provide personal care services to me to follow the following instructions that are relevant to the decisions to be made:

additional page attached? ☐ Yes ☐ No

6. Other Information (optional)

Witness' Initials Your Initials

I provide the following information to help my delegate(s) or statutory decision-maker understand my values, beliefs and wishes when making decisions about my personal care:

additional page attached? ☐ Yes ☐ No

7. Instructions about Statutory Decision-makers (optional)

Witness' Initials Your Initials

I **DO NOT** wish to authorize a delegate and am comfortable with a relative authorized under section 14 of the Personal Directives Act making decisions on my behalf about health care, home care and placement in a continuing care home, except I **DO NOT** want the following relative(s) making decisions on my behalf:

Name	Relationship
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8. Consultation when Delegate Making Decisions (optional)

Witness' Initials Your Initials

My delegate(s) is to consult with the following person(s) when making decisions about my personal care.

Name: _____
Print Name of Delegate

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

9. Notification (optional)

Witness' Initials Your Initials

If it is determined that I lack capacity to make a personal care decision,
I instruct the person making the determination to notify me, the delegate(s)
I have authorized in this Personal Directive, if any, and the following people:

Witness' Initials Your Initials

If is determined that I lack capacity to make a personal care decision,
the following people are not to be notified of the determination:

10. Compensation for Personal Care Services (optional)

Witness' Initials Your Initials

My delegate, _____, is authorized to
Name of Delegate
receive compensation for providing me with personal care services on the following terms:

11. Remuneration for Delegate (optional)

Witness' Initials Your Initials

My delegate, _____, is authorized

Name of Delegate

to receive remuneration for exercising his/her authority under this personal directive on the following terms:

12. Signatures (mandatory)

Signed by me in the presence of my witness at _____, in the Province of

Location

Nova Scotia, this _____ day of _____, _____

Day

Month

Year

Printed Name of Witness

Printed Name of Maker

Relationship to Maker

Signature of Maker in the presence of the Witness

Signature of Witness in the presence of the Maker

Street Address

Street Address

City/Town

City/Town

Province

Province

Home Phone Number

Business Phone Number

Home Phone Number

Business Phone Number

Email

Email

OR (where Maker physically unable to sign)

Signed on behalf of the Maker, _____, in the presence of the
Name of Maker

Maker **and** in the presence of the witness at _____, in the Province of
Location

Nova Scotia, this _____ day of _____, _____.
Day Month Year

Print Name of Person signing on behalf of Maker

Print Name of Witness

Relationship to Maker

Signature of Person signing on behalf of Maker
in the presence of the Maker

Signature of Witness in the presence of the Maker

Street Address

Street Address

City/Town

City/Town

Province

Province

Home Phone Number Business Phone Number

Home Phone Number Business Phone Number

Email

Email