

**STATEMENT BY A CLOSE FRIEND
BEFORE THEY ARE CHOSEN AS A
SUBSTITUTE DECISION-MAKER**

I N S T R U C T I O N S

This form is to be filled out by a close friend before they are chosen to act as a substitute decision-maker for a care recipient who is incapable of making their own care decision. The close friend should keep a copy of this form. The original should be placed on the care recipient's health record.

Care recipient _____
Print full name

_____ Address _____ Phone number _____

Close friend making this statement _____
Print full name

_____ Address _____ Phone number _____

Statement

1. I am a close friend of _____ named above, and
Care recipient
maintain a close personal relationship with him/her. I have a personal interest in his/her well-being and will carry out the duties of a substitute decision-maker as outlined in the *Care Consent Act*. I am _____ years old. I have known _____ for _____ years/months.
Care recipient

2. Over the past three months I estimate that I have been in contact with _____
Care recipient this often: _____.

I would describe the nature of this contact as: _____

3. I consider myself to be a close friend of _____
Care recipient

because _____

DATED at _____,
this _____ day of _____ month, _____ year.

} _____
SIGNATURE OF CLOSE FRIEND

} _____
PRINTED NAME OF CLOSE FRIEND

Information on this form is being collected, pursuant to the *Care Consent Act*, to meet the requirements for a close friend to act as a substitute decision-maker. For more information, contact the Health and Social Services ATIPP Coordinator (H-1), Box 2703, Whitehorse, Yukon Y1A 2C6, (867) 667-3010.