

**Request for Medication to End My Life in a Peaceful Manner**

I, \_\_\_\_\_ am an adult of sound mind. I am suffering from \_\_\_\_\_, which my attending physician has determined is a terminal illness and which has been medically confirmed. I have been fully informed of my diagnosis and prognosis of six months or less, the nature of the medical aid-in-dying medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control.

I request that my attending physician prescribe medical aid-in-dying medication that will end my life in a peaceful manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request. I understand that I have the right to rescind this request at any time. I understand the seriousness of this request, and I expect to die if I take the aid-in-dying medication prescribed.

I further understand that although most deaths occur within three hours, my death may take longer, and my attending physician has counseled me about this possibility. I make this request voluntarily, without reservation, and without being coerced, and I accept full responsibility for my actions.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

**Declaration of Witnesses**

We declare that the individual signing this request:

Is personally known to us or has provided proof of identity; signed this request in our presence; appears to be of sound mind and not under duress, coercion, or undue influence; and

I am not the attending physician for the individual.

\_\_\_\_\_/\_\_\_\_\_  
witness 1/date

\_\_\_\_\_/\_\_\_\_\_  
witness 2/date

Note: of the two witnesses to the written request, at least one must not:

Be a relative (by blood, marriage, civil union, or adoption) of the individual signing this request; be entitled to any portion of the individual's estate upon death; or own, operate, or be employed at a health care facility where the individual is a patient or resident.

And neither the individual's attending physician nor a person authorized as the individual's qualified power of attorney or durable medical power of attorney shall serve as a witness to the written request.