

**REQUEST FOR MEDICATION TO END MY LIFE
IN A PEACEFUL MANNER**

I, _____, am an adult of sound mind.
I am suffering from a terminal illness, which is a disease or condition that is incurable and irreversible and that, according to reasonable medical judgment, will result in death within six months. My health care provider has determined that the illness is in its terminal phase. _____ (Patient Initials)
I have been fully informed of my diagnosis and prognosis, the nature of the medical aid in dying medication to be prescribed and the potential associated risks, the expected result and the feasible alternative, concurrent or additional treatment opportunities, including hospice care and palliative care focused on relieving symptoms and reducing suffering. _____ (Patient Initials)
I request that my health care provider prescribe medication that will end my life in a peaceful manner if I choose to self-administer the medication, and I authorize my health care provider to contact a willing pharmacist about to fulfill this request. _____ (Patient Initials)
I understand that I have the right to rescind this request at any time. _____ (Patient Initials)
I understand the full import of this request, and I expect to die if I self-administer the medical aid in dying medication prescribed. I further understand that although most deaths occur within three hours, my death may take longer. My health care provider has counseled me about this possibility. _____ (Patient Initials)

I make this request voluntarily and without reservation.
Signed: _____
Date: _____ Time: _____

DECLARATION OF WITNESSES:

We declare that the person signing this request:

1. is personally known to us or has provided proof of identity;
2. signed this request in our presence;
3. appears to be of sound mind and not under duress, fraud or undue influence; and
4. is not a patient for whom either of us is a health care provider.

	Witness 1:	Witness 2:
Signature:	_____	_____
Printed Name:	_____	_____
Relationship to Patient:	_____	_____
Date:	_____	_____

NOTE: No more than one witness shall be a relative by blood, marriage or adoption of the person signing this request. No more than one witness shall own, operate or be employed at a health care facility where the person signing that request is a patient or resident.

Provider Attestation (optional):

Signature of the Prescribing Provider

Date Prescription Written

NOTE: The Provider Attestation is not mandatory nor necessary to be included on this Request form. However, the Office of Medical Investigator may require proof that the individual is a Medical Aid-in-Dying patient. Having a copy of both the Request form and such Attestation of Prescription readily available in the medical record and on hand with the individual is strongly advised.