REQUEST FOR MEDICATION
TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending/prescribing physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of: my diagnosis; prognosis; the nature of medication to be prescribed and potential associated risks; the expected result; and feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending/prescribing physician prescribe medication that will end my life in a humane and dignified manner and also contact any pharmacist to fill the prescription.

Initial One

☐ I have informed my family of my decision and taken their opinions into consideration.

☐ I have decided not to inform my family of my decision.

☐ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

I further understand that although most deaths occur within three hours, my death may take longer and my physician has counseled me about this possibility.

Signature:	County of Residence:	Date:

DECLARATION OF WITNESSES

By *initialing* and *signing* below, we declare that the person making and signing the above request:

Witness 1	Witness 2	
☐	☐	1. Is personally known to us or has provided proof of identity;
☐	☐	2. **Signed this request in our presence on the date following the person's signature;**
☐	☐	3. Appears to be of sound mind and not under duress, fraud or undue influence;
☐	☐	4. Is not a patient for whom either of us is the attending physician.

Printed Name: Witness 1	Signature:	Date:
Printed Name: Witness 2	Signature:	Date:

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a long-term health care facility, one of the witnesses shall be an individual designated by the facility.

PLEASE MAKE A COPY OF THIS FORM TO KEEP IN YOUR HOME