DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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

I,_____ am an adult of sound mind.
First (Please Print) Middle Last

I am suffering from _____, which my attending 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, 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 physician prescribe medication that will end my life in a humane and peaceful manner.

Initial One

☐ I have informed my family of my decision and taken their opinion 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 further understand that although most deaths occur within three (3) hours of taking the medication to be prescribed, my death may take longer, and my physician has counseled me about this possibility.

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

I declare that I am of sound mind and not acting under duress, fraud, or undue influence and I am a District of Columbia resident.

Further, I am acknowledging that I am aware of District of Columbia Death with Dignity Act of 2016 (D.C. Official Code § 7-661.01 et seq.) and reviewed the Patient Education Module.

Signature:	Date:

DESIGNATION TO DISPOSE OF UNUSED COVERED MEDICATION (OPTIONAL)

I have designated _____ to safely dispose of unused covered medication.
First (Please Print) MI Last

I agree to safely dispose of unused medication for the individual identified in this form.

Signature:	Date:

March 14, 2018

DC HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

DECLARATION OF WITNESSES

We declare that the person signing this request:

Please Initial

Witness 1	Witness 2	
☐	☐	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;
☐	☐	4. Is not a patient for whom either of us is the attending physician.
☐	☐	5. Is not 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. (Can only be attested by one witness.)

Name (Witness 1):	Address:
Signature:	Date:
Name (Witness 2):	Address:
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 a patient at a long-term care facility, one of the witnesses shall be an individual designated by the facility.

DOH DWD Patient Form March 13, 2018