



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

I, \_\_\_\_\_ am an adult of sound mind.  
First Middle Last

I am suffering from \_\_\_\_\_, which my attending physician has determined is an incurable, irreversible terminal disease that will result in death within six months 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 physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and dispense or to contact a pharmacist to dispense 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 further understand that although most deaths occur within three hours, 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 further declare that I am of sound mind and not acting under duress, fraud, or undue influence.

Signature:	County of Residence:	Date:
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### DECLARATION OF WITNESSES

By initialing and signing below in the presence of the person named above signs, we declare that the person making and signing the above request:

Witness 1   Witness 2

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Is personally known to us or has provided proof of identity;                      |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Signed this request in our presence on the date following the person's signature; |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Appears to be of sound mind and not under duress, fraud or undue influence;       |
| <input type="checkbox"/> | <input type="checkbox"/> | 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: Only one of two witnesses may be a relative by blood, marriage, or adoption of the person signing this request, or be entitled to any portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident. The patient's attending physician at the time of the request is not eligible to be a witness. 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.