REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, ________________________________, am an adult of sound mind and a resident of the State of California.

I am suffering from ________________________________, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

**INITIAL ONE:**

_____ I have informed one or more members of 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 withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Sign: ________________________________________________________________

Date: __________________________

(continued)
DECLARATION OF WITNESSES

We declare that the person signing this request:

a. Is personally known to us or has provided proof of identity;

b. Voluntarily signed this request in our presence;

c. Is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and

d. Is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

Witness 1 Signature ___________________________________________ Date

Witness 2 Signature ___________________________________________ Date

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a 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.

INTERPRETER

I, _____________________________(insert name of interpreter), am fluent in English and _____________________________ (insert target language).

On _____________________________ (insert date) at approximately ______________ (insert time), I read the “Request for an Aid-In-Dying Drug to End My Life” to _____________________________ (insert name of individual/patient) in _____________________________ (insert target language).

Mr./Ms. _____________________________ (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and _____________________________ (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.

Executed at _____________________________ (insert city, county, and state) on this _____________________________ (insert day of month) of _____________________________ (insert month), __________ (insert year).

Interpreter signature _____________________________________________

Interpreter printed name ___________________________________________

Interpreter address ____________________________________________

(02/16) Page 2 of 2 California Hospital Association