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.

Signed:_____ **Dated:**_____

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:_____ **Date:**_____

Witness 2:_____ **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 entity where the person is a patient or resident.