Request for Medication to End My Life

Declaration of Witnesses

Name of patient: _____ ("Patient")

I, _____ (Name of Witness 1), and
I, _____ (Name of Witness 2), each declare that the person signing this "Request for Medication to End My Life":

1. is personally known to me or has provided proof of identity;
2. voluntarily signed the "Request for Medication to End My Life" in my presence or acknowledged to me that they signed it; and
3. to the best of my knowledge and belief, has decision-making capacity and is making the "Request for Medication to End My Life" voluntarily, of the person's own volition and is not being coerced to sign the "Request for Medication to End My Life."

I am not the attending physician or consulting physician of the person signing the "Request for Medication to End My Life" or the mental health professional who provided a decision-making capacity determination for the person signing the "Request for Medication to End My Life" at the time the "Request for Medication to End My Life" was signed.

I further declare under penalty of perjury that the statements made herein are true and correct and false statements made herein are punishable.

I further declare that I am not:

1. related to Patient by blood, marriage or adoption;
2. entitled to any portion of the estate of Patient upon their death under any will or by operation of law, and I am not otherwise in a position to benefit financially from Patient's death;
3. an owner, operator, employee or independent contractor of a health care facility where Patient is receiving treatment or is a resident;
4. a domestic partner of Patient, as defined in New York's Family Health Care Decisions Act, Public Health Law Section 2994-a(7);
5. the health care agent under Patient's health care proxy, Public Health Law Section 2980(5); or
6. an agent under Patient's power of attorney, General Obligations Law Section 5-1501(2).

Signature of Witness 1: _____ Date: _____

Address: _____

Signature of Witness 2: _____ Date: _____

Address: _____

Request for Medication to End My Life

I, _____ (Name of patient), am an adult New York State resident who has been diagnosed with _____ (Name of terminal illness or condition), a terminal illness or condition. My attending physician has determined, and a consulting physician has confirmed, that my terminal illness or condition is an incurable and irreversible illness or condition that will, within reasonable medical judgment, produce death within six months whether or not treatment is provided.

My attending physician, consulting physician, and a mental health professional agree that I have decision-making capacity, which means that I understand and appreciate the nature and consequences of Medical Aid in Dying, including the benefits, risks, and alternatives, and I have the ability to make an informed decision about Medical Aid in Dying and to communicate my decision to my attending physician.

I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives and treatment options, including but not limited to palliative care and hospice care.

I request that my attending physician prescribe medication that will end my life if I choose to take it, and I authorize my attending physician to contact another physician or any pharmacist about my request.

Initial One:

(_____) I have informed or intend to inform one or more members of my family of my decision.

(_____) I have decided not to inform any member of 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 or decline to use the medication at any time.

I understand the importance of this request, and I expect to die if 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 attending physician has counseled me about this possibility.

I make this request voluntarily, of my own volition and without being coerced, and I accept full responsibility for my actions.

Signature: _____ Date: _____

Witness 1 ("Declaration of Witnesses" is attached to this "Request for Medication to End My Life")

Signature: _____ Date: _____

Name (Print): _____

Address: _____

Witness 2 ("Declaration of Witnesses" is attached to this "Request for Medication to End My Life")

Signature: _____ Date: _____

Name (Print): _____

Address: _____

Declaration of Interpreter (If applicable)

Name of patient: _____ ("Patient")

I, _____ (Name of Interpreter):

(Check one of the two options below)

☐ for Patient whose conversations or consultations or interpreted conversations or consultations were conducted in a language other than English and the "Request for Medication to End My Life" is in English: I declare that I am fluent in English and _____ ("Target Language"). I have the requisite language and interpreter skills to be able to interpret effectively, accurately and impartially information shared and communications between the attending or consulting physician and Patient.

I certify that on _____ (Date/Time), I interpreted the communications and information conveyed between the physician and Patient impartially and as accurately and completely to the best of my knowledge and ability and read the "Request for Medication to End My Life" to Patient in Target Language.

Patient affirmed to me their desire to sign the "Request for Medication to End My Life" voluntarily, of Patient's own volition and without coercion.

☐ for Patient with a speech, hearing or vision disability: I declare that I have the requisite language, reading and/or interpreter skills to communicate with Patient and to be able to read and/or interpret effectively, accurately and impartially information shared and communications between the attending or consulting physician and Patient.

I certify that on _____ (Date/Time), I interpreted the communications and information conveyed between the physician and Patient impartially and as accurately and completely to the best of my knowledge and ability and, where needed for effective communication, read or interpreted the "Request for Medication to End My Life" to Patient.

Patient affirmed to me their desire to sign the "Request for Medication to End My Life" voluntarily, of Patient's own volition and without coercion.

I declare that I am not:

1. related to Patient by blood, marriage or adoption;
2. entitled to any portion of the estate of Patient upon Patient's death under any will or by operation of law, and I am not otherwise in a position to benefit financially from Patient's death;
3. an owner, operator, employee or independent contractor of a health care facility where Patient is receiving treatment or is a resident; or that I am providing interpreter services as part of my job description at such health care facility; or that I have been trained to provide interpreter services and Patient requested that I provide interpreter services for the purposes stated in this Declaration;
4. a domestic partner of Patient, as defined in New York's Family Health Care Decisions Act, Public Health Law Section 2994-a(7);
5. the health care agent under Patient's health care proxy, Public Health Law Section 2980(5); or
6. an agent under Patient's power of attorney, General Obligations Law Section 5-1501(2).

I further declare that this Declaration is true and correct, and that false statements made in this Declaration are punishable under penalty of perjury.

Executed at: _____ (City, County and State)

Signature: _____ Date: _____

Name (Print): _____

Institution where Interpreter was trained: _____

Address of institution where
Interpreter was trained: _____

Target Language Spoken by Interpreter: _____