DISTRICT OF COLUMBIA DEATH WITH DIGNITY ACT PATIENT REQUEST FORM

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

I, _____, am an adult of sound mind. 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 the 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 dignified 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 as 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 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.

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) Signed this request in our presence;
(c) Appears to be of sound mind and not under duress, fraud, or undue influence;
(d) Is not a patient for whom either of us is the attending physician.

Date: _____
Witness 1:_____
Address: _____
Witness 1 signature: _____

Date: _____
Witness 2:_____
Address: _____
Witness 2 signature: _____

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 the health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.