New Jersey Department of Health

MEDICAL AID IN DYING FOR THE TERMINALLY ILL ACT
MEDICATION DISPENSING RECORD

Filing Instructions:

1. This form must be completed by the physician or pharmacist who dispensed medication under the Medical Aid in Dying Act (MAID) (P.L.2019, c.59).
2. The physician or pharmacist must file as soon as possible and no later than 30 days after the dispensement of medication(s) for MAID.
3. Forms shall be filed with the New Jersey Office of the Chief State Medical Examiner at:
   PO Box 182
   Trenton, NJ 08625

   Or you may submit your digitally signed form(s) to OCSME staff via email at maid@doh.nj.gov.

Date of Report Mailing: _____
[Month/Day/Year]

PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*
Patient's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	

ATTENDING PHYSICIAN INFORMATION			
Physician's Name:	*[Last Name, First Name, Middle Name]*	Physician's Telephone Number:	*[10-digit]*
Physician's DEA Number:		Date Prescription Issued:	*[Month/Day/Year]*
Physician's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	

DISPENSING HEALTH CARE PROVIDER INFORMATION			
Provider's Name:	*[Last Name, First Name, Middle Name]*	Provider's Telephone Number:	*[10-digit]*
Provider's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Pharmacy Permit Number:			

Blank forms available at: http://nj.gov/health/maid

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PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*

MEDICATION DISPENSED						
Medication Name	Quantity	Strength	Date Prescribed (Month/Day/Year)	Date Dispensed (Month/Day/Year)	National Drug Code	Refill or New Prescription?

May attach additional pages as necessary.

Were any refills ordered? ☐ No ☐ Yes: _____

Source of Payment for the medication(s) dispensed: _____

Medication must be directly dispensed to either the patient, the attending physician, or an expressly identified agent of the patient.

Name of the Patient's Expressly Identified Agent (if applicable):

_____
[Last Name, First Name, Middle Name]

AUTHORIZATION

I am authorized under law to dispense and have a current federal Drug Enforcement Administration certificate of registration.

Signature: _____ Applicable DEA Number: _____

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