New Jersey Department of Health

MEDICAL AID IN DYING FOR THE TERMINALLY ILL ACT
MENTAL HEALTH PROFESSIONAL COMPLIANCE FORM

Filing Instructions:

1. Must be completed by the Mental Health Professional to whom either the Attending Physician or the Consulting Physician referred the Patient for determination of capability under the Medical Aid in Dying Act (P.L. 2019, c.59).
2. The Mental Health Professional must deliver the completed form to the Attending Physician.
3. The Attending Physician must append this form to Attending Physician Compliance Form, which must be filed no later than 30 days after the date of the qualified terminally ill patient's death.
4. 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 electronically via email at maid@doh.nj.gov

Date: _____
[Month/Day/Year]

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

REFERRING PHYSICIAN'S INFORMATION			
Physician's Name:	*[Last Name, First Name, Middle Name]*	Physician's Telephone Number:	*[10-digit]*
Physician's Facility Name:			
Physician's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Physician's License Number:			

MENTAL HEALTH PROFESSIONAL'S INFORMATION			
Professional's Name:	*[Last Name, First Name, Middle Name]*	Professional's Telephone Number:	*[10-digit]*
Professional's Facility Name:			
Professional's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Professional's License Number:			

PATIENT ELIGIBILITY DETERMINATION BY MENTAL HEALTH PROFESSIONAL

CHECK ALL THAT APPLY:

- ☐ In my professional opinion, the patient requesting medication is capable.
- ☐ In my professional opinion, the patient requesting medication is not capable.
- ☐ I have notified the patient's attending physician in writing of the patient's capability.

AUTHORIZATION

Signature: _____ Date: _____
[Month/Day/Year]

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