New Jersey Department of Health

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

Upon completion of this form, the New Jersey Department of Health:

1. Requires that the Attending Physician retain a copy of this form. This completed form must be attached to Attending Physician Compliance Form, which must be filed with the Office of the Chief State Medical Examiner no later than 30 days after the date of the qualified terminally ill patient's death.
2. Advises the Patient to retain a copy of this form. If a Patient intends to self-administer prescribed medications outside of a facility, the Department of Health encourages the patient to leave this form in view when the medication is ingested to facilitate timely reporting.
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 electronically via email at maid@doh.nj.gov
4. *To report the death of the Patient listed on this form, please notify the New Jersey Department of Health at 973-648-4500.*

I, _____, am an adult of sound mind
[Last Name, First Name, Middle Name]

and a resident of New Jersey. I am suffering from _____,
[Terminal Illness, Disease, or Condition]
which my attending physician has determined is a terminal illness, disease, or condition and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result; and feasible alternatives, including concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control.

I request that my attending physician prescribe medication that I may self-administer to end my life in a humane and dignified manner and to contact any pharmacist as necessary to fill the prescription.

INITIAL ONE:
_____ I have informed 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.

INITIAL ALL THAT APPLY:
_____ My attending physician has recommended that I participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options, and provided me with a referral to a health care professional qualified to discuss these options with me.
_____ I have participated in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options.
_____ I am currently receiving palliative care, comfort care, or hospice care.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request, and I expect to die if and when 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 physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full responsibility for my decision.

Signed: _____

Dated: _____ Time of Request: _____
[Month/Day/Year] *[12-Hour Format AM/PM]*

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

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DECLARATION OF WITNESSES

PATIENT INFORMATION	
Patient's Name:	*[Last Name, First Name, Middle Name]*

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Witness 1	Witness 2	
_____	_____	1. Is personally known to us or has provided proof of identity.
_____	_____	2. Signed this request in our presence on the date of the person's signature.
_____	_____	3. Appears to be of sound mind and not under duress, fraud, or undue influence.
_____	_____	4. Is not a patient for whom either of us is the attending physician.

WITNESS 1			
Printed Name of Witness 1:	*[Last Name, First Name, Middle Name]*	Dated:	*[Month/Day/Year]*
Signature of Witness 1:		Time of Declaration 1:	*[12-Hour Format AM/PM]*

WITNESS 2			
Printed Name of Witness 2:	*[Last Name, First Name, Middle Name]*	Dated:	*[Month/Day/Year]*
Signature of Witness 2:		Time of Declaration 2:	*[12-Hour Format AM/PM]*

NOTE: At least 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 the person's death under any will or by operation of law, and shall not own, operate, or be an owner, operator, or employee of a health care facility, other than a long term care facility, where the person is a patient or resident. The person's attending physician at the time the request is signed shall not serve as a witness.

PATIENT'S DESIGNEE RESPONSIBLE FOR THE LAWFUL DISPOSAL OF THE MEDICATION(S)			
Designee's Name:	*[Last Name, First Name, Middle Name]*	Designee's Telephone Number:	*[10-digit]*
Designee's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Date of Designation:	*[Month/Day/Year]*	Designee's Signature:	