FORM 5-5

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind and a resident of the State of California.

I am suffering from _____, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

_____ I have informed one or more members of 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.

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

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Sign:_____.

Date: _____

(continued)

DECLARATION OF WITNESSES

We declare that the person signing this request:

a. Is personally known to us or has provided proof of identity;

b. Voluntarily signed this request in our presence;

c. Is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and

d. Is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

_____ _____

Witness 1 Signature *Date*

_____ _____

Witness 2 Signature *Date*

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

INTERPRETER

I, _____*(insert name of interpreter)*, am fluent in English and _____ *(insert target language)*.

On _____ *(insert date)* at approximately _____ *(insert time)*, I read the "Request for an Aid-In-Dying Drug to End My Life" to _____ _____ *(insert name of individual/patient)* in _____ _____ *(insert target language)*.

Mr./Ms. _____ *(insert name of patient/qualified individual)* affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and _____ *(insert target language)* and further declare under penalty of perjury that the foregoing is true and correct.

Executed at _____*(insert city, county, and state)* on this *(insert day of month)* of _____ *(insert month)*, _____ *(insert year)*.

_____

Interpreter signature

_____

Interpreter printed name

_____

Interpreter address