



DT9236

## REQUEST FOR MEDICAL AID IN DYING

Last name		
First name		
Date of birth		Year   Month   Day
Health insurance number	Expiry	Year   Month
Address		
Postal code	Area code	
Telephone no.		

**I request that Dr. (name of physician) administer me medical aid in dying. I have received the necessary information regarding the conditions required to obtain and have access to this aid.**

I authorize the pharmacist, who will provide the medications for administering me medical aid in dying, to receive a copy of my request.

Signature (patient): \_\_\_\_\_

Date 

Year	Month	Day
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**Authorized third person<sup>1</sup>:** If the patient requesting medical aid in dying cannot date and sign the form because he or she cannot write or is physically incapable of doing so, a third person may do so in the patient's presence and according to his or her instructions.

First and last name of the authorized third person:

Domiciled at (address):

Relation to the patient requesting medical aid in dying:

Signature: \_\_\_\_\_

Date 

Year	Month	Day
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### Health or social services professional present when the person requesting medical aid in dying or the authorized third person signed and dated the form:

First and last name	Title	Licence No.
Signature of professional		Year   Month   Day
<b>Independent witness present when the person requesting medical aid in dying or the authorized third person signed and dated the form<sup>2</sup>:</b>		<b>Date</b>
<b>Witness 1:</b> First and last name	Signature	Year   Month   Day

The original of this form must be given to the attending physician and filed in the record of the patient requesting medical aid in dying in accordance with section 32 of the Act respecting end-of-life care.

<sup>1</sup> In accordance with Section 27 of the Act Respecting End-of-Life Care and in view of Section 241.2(4) of the Criminal Code, the third person may not be a member of the team responsible for caring for the patient, a minor or a person of full age incapable of giving consent, or know or believe that he or she is the beneficiary under the will of the person making the request or otherwise a recipient of a financial or other material benefit from that person's death. The third person must also understand the nature of a request for medical aid in dying.

<sup>2</sup> Section 241.2(5) of the Criminal Code stipulates that the request must be signed and dated in front of an independent adult witness who understands the nature of a request for medical aid in dying. A witness cannot be considered independent if they a) know or believe that they are a beneficiary under the will of the person making the request or otherwise a recipient of a financial or other material benefit resulting from that person's death, b) is an owner or operator of a healthcare facility at which the person making the request is being treated or in which that person resides, c) is directly involved in providing healthcare services to the person making the request, or d) directly provides personal care to the person making the request.