Janet T. Mills
Governor

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Commissioner

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Request for Medication to End My Life in a Humane and Dignified Manner

Part One: Declaration of Patient

I, _____, am an adult of sound mind and am a resident of the State of Maine and have been since _____ (month) of _____ (year) and I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result and feasible alternatives, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.

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

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 when I take the medication to be prescribed. I further understand that, although most deaths occur within 3 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 moral responsibility for my actions.

Signature	Date

Part Two: Declaration of Witnesses

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

Initials of Witness 1:

_____ 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; and

_____ 4. Is not a patient for whom either of us is the attending physician.

Witness 1 Print name	Signature	Date

Initials of 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; and

_____ 4. Is not a patient for whom either of us is the attending physician.

Witness 2 Print name	Signature	Date

NOTE: One witness must be a person who is not a relative by blood, marriage, or adoption of the person signing this request, is not entitled to any portion of the person's estate upon death and does not own or operate or is not employed at a health care facility where the person is a patient or resident. The person's attending physician at the time of the request is signed may not be a witness. If the person is an inpatient at a long-term care facility, one of the witnesses must be a licensed healthcare provider designated by the facility; the facility's designee may be an owner, operator, or employee of the health care facility.

To the person signing this request:

Give this completed form to your attending physician. Request a copy to keep for yourself.

To the attending physician:

Retain this completed original form in the patient's medical record. Provide a copy to the State Registrar, Office of Data, Research, and Vital Statistics.