



## **INSTRUCTIONS FOR FILLING OUT “REQUEST FOR MEDICATION” FORM**

DO NOT sign this form until you have seen both an Attending (prescribing) and a Consulting Physician who have agreed to participate in the Washington Death with Dignity Act and submit the state forms required.

If you are unable to sign your name, you may sign an alternative mark, as long as witnesses recognize that it represents your signature. A common alternative mark is an “X”.

Please read the note on the form about who may, and may not, be a witness. Both witnesses must see you sign this form. All dates on this form must be identical, or the form is invalid.

- One copy of the “Request for Medication” form goes to the Attending (prescribing) Physician.
- We recommend keeping one copy for your records.

If you have questions or if you would like assistance completing this form, contact End of Life Washington.

*End of Life Washington is a nonprofit organization that provides information, counseling, and emotional support to people facing terminal or irreversible illness. We advocate for excellent end-of-life care, the use of advance directives, and patient-centered care. We uphold the right of qualified patients to use Washington’s Death with Dignity Act. Confidentiality is strictly protected. There is never a fee for our services.*

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

I, \_\_\_\_\_, am an adult of sound mind.  
First Middle Last

I am suffering from \_\_\_\_\_, which my attending physician has determined is an incurable, irreversible terminal disease that will result in death within six months 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 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 dispense or to contact a pharmacist to dispense 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 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 moral responsibility for my actions.

I further declare that I am of sound mind and not acting under duress, fraud, or undue influence.

Signature:	County of Residence:	Date:
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## 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 the above request:

Witness 1    Witness 2  
 Initials    Initials

- |       |       |  |
|-------|-------|--|
| _____ | _____ | 1. Is personally known to us or has provided proof of identity;                      |
| _____ | _____ | 2. Signed this request in our presence on the date following 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.                |

Printed Name: Witness 1	Signature:	Date:
Printed Name: Witness 2	Signature:	Date:

**NOTE: One witness cannot be a person who: (1) is related by blood, marriage, or adoption to the person making this request or (2) is entitled to any portion of the person's estate upon death or (3) owns, operates, or is employed at a healthcare facility where the person making this request is receiving medical treatment or is a resident. The other witness may be related by blood, marriage, etc. The attending (prescribing) physician cannot be a witness.**

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

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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.

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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 three hours, my death may take longer and my physician has counseled me about this possibility.

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- |       |       |  |
|-------|-------|--|
| _____ | _____ | 1. Is personally known to us or has provided proof of identity;                      |
| _____ | _____ | 2. Signed this request in our presence on the date following 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.                |

Printed Name: Witness 1	Signature:	Date:
Printed Name: Witness 2	Signature:	Date:

**NOTE: One witness cannot be a person who: (1) is related by blood, marriage, or adoption to the person making this request or (2) is entitled to any portion of the person's estate upon death or (3) owns, operates, or is employed at a healthcare facility where the person making this request is receiving medical treatment or is a resident. The other witness may be related by blood, marriage, etc. The attending (prescribing) physician cannot be a witness.**