

Medical Assistance in Dying means: (a) the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or (b) the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death.

Authorized third person is a person who is at least 18 years of age and who understands what it means to request medical assistance in dying and who does not know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death may sign and date the request in the presence and on behalf of the person requesting medical assistance in dying.

An independent witness is any person who is at least 18 years of age and who understands the nature of the request for medical assistance in dying may act as an independent witness, except if they (a) know or believe that they are a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death; (b) are an owner or operator of any health care facility at which the person making the request is being treated or any facility in which that person resides; (c) are directly involved in providing health care services to the person making the request; or (d) directly provide personal care to the person making the request.

A person is considered to have a **grievous and irremediable** medical condition where:

- they have a serious and incurable illness, disease or disability; and,
- they are in an advanced state of irreversible decline in capability; and,
- they are experiencing enduring physical or psychological suffering, due to the illness, disease, disability or state of decline, that is intolerable to the person and cannot be relieved in a manner that they consider acceptable; and,
- the person's natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without requiring a specific prognosis as to the length of time the person has left to live.

The use of this aid is voluntary. It is being provided to assist you in making a written request for medical assistance in dying that complies with the legal requirements.

Once you complete this request, you should provide it to your doctor or nurse practitioner. The completed aid may be included in your medical records and may be used by your doctor or nurse practitioner to provide health care to you.

Section 1 – Patient Information

Last Name		First Name	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth (yyyy/mm/dd)	Health Insurance Number (e.g., OHIP Number) <input type="checkbox"/> Not Applicable	Version Code
Province or Territory that Issued Health Insurance Number		Postal Code Associated with Patient's Home Address <input type="checkbox"/> Patient does not have a home address	

Section 2 – Request for Medical Assistance in Dying

You must personally complete this section unless you are unable to do so. If you are unable to complete this section, you may ask an **authorized third person** to complete it for you.

I, _____
(Last Name, First Name)

request that a doctor or nurse practitioner help me to die. I confirm that:

- I am eligible for health services funded by a government in Canada (i.e., I have a valid OHIP card or proof of other Canadian publicly-funded health insurance – e.g., from another province) or, but for any applicable minimum period of residence or waiting period, I would be eligible for health services funded by a government in Canada.
- I am at least 18 years of age.
- I have been informed by my doctor or nurse practitioner that I have a **grievous and irremediable** condition.
- I am asking for help to die voluntarily and not as a result of pressure from others.

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)
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I am giving my informed consent to receive medical assistance in dying, and have been informed of the means that are available to me to relieve my suffering, including palliative care.

Signature (Patient)	Date (yyyy/mm/dd)
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Section 3 – Authorized Third Person (where the person requesting medical assistance in dying is unable to sign and date the request)

Last Name	First Name
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Current Address

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone Number ext.	Relationship to Person Requesting Medical Assistance in Dying		

By signing below on the person's behalf, I declare that:

- I am at least 18 years of age;
- I understand the nature of the person's request for medical assistance in dying;
- I do not know or believe that I am a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death; and
- I am signing under the person's presence, on the person's behalf and under the person's express direction.

Signature (Third Person)	Date (yyyy/mm/dd)
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Section 4 – Witnesses Present Upon Signing and Declaration of Witnesses

This section must be completed by two independent witnesses.

Witness #1 Information

Last Name	First Name
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Current Address

Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code
Telephone Number ext.	Relationship to Person Requesting Medical Assistance in Dying		

By signing below, I declare that:

- I am at least 18 years of age;
- I understand the nature of the person's request for medical assistance in dying;
- The patient (or authorized third person, in the presence and at the express direction of the patient) signed the request for medical assistance in dying in my presence and in the presence of the other independent witness;
- I am signing under the person's direction; and

Last Name of Patient	First Name of Patient	Date of Birth of Patient (yyyy/mm/dd)
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- I do not know or believe that I am a) a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, b) an owner or operator of any health care facility at which the person making the request is being treated or where the person resides, c) are directly involved in providing health care or d) personal care to the person.

Signature (Witness #1)	Date (yyyy/mm/dd)
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Witness #2 Information	
Last Name	First Name

Current Address			
Unit Number	Street Number	Street Name	PO Box
City/Town		Province	Postal Code

Telephone Number ext.	Relationship to Person Requesting Medical Assistance in Dying
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By signing below, I declare that:

- I am at least 18 years of age;
- I understand the nature of the person's request for medical assistance in dying;
- The patient (or authorized third person, in the presence and at the express direction of the patient) signed the request for medical assistance in dying in my presence and in the presence of the other independent witness;
- I am signing under the person's direction; and
- I do not know or believe that I am a) a beneficiary under the will of the person making the request, or a recipient, in any other way, of a financial or other material benefit resulting from that person's death, b) an owner or operator of any health care facility at which the person making the request is being treated or where the person resides, c) are directly involved in providing health care or d) personal care to the person.

Signature (Witness #2)	Date (yyyy/mm/dd)
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