Washington State Department of HEALTH

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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

The Washington Death with Dignity Act (chapter 70.245 RCW) allows a qualified patient with a terminal illness with six months or less to live to request medication that the patient may self-administer to end their life. If you have questions about these instructions, contact DeathwithDignity@doh.wa.gov.

Qualified Patient Requirements

A qualified patient must be:

- At least 18 years of age.
- Competent - in the opinion of a court or in the opinion of the patient's attending qualified medical provider or consulting qualified medical provider, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
- A resident of Washington State.
- Diagnosed with a terminal disease - an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.

Common documents that prove residency in Washington State include, but are not limited to: a driver's license, voter registration, a mortgage or rental agreement, or a utility bill.

Witness Requirements

- Only one of two witnesses may be your relative by blood or by law or entitled to any portion of your estate upon death.
- Only one of the two witnesses may own, operate, or be employed at a health care facility where you are a patient or resident.
- Your attending qualified medical provider at the time of the request cannot be a witness.

Note for the Attending Qualified Medical Provider

The Death with Dignity Act only provides immunity from civil and criminal liability and disciplinary action for good faith compliance. You must submit the following completed forms **within 30 calendar days** of writing a prescription for a lethal dose of medication:

Send the completed forms to the Department of Health.

- **Online through REDCap:** https://redcap.link/DeathWithDignity**.**
- By fax: 360-200-7408
- By mail: Center for Health Statistics, PO Box 47856, Olympia, WA 98504-7856

The Department of Health will contact you if the forms are missing information. We keep all information strictly confidential and only release aggregate information on an annual basis.

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

Name (First, Middle, Last): _____ Date of birth: _____

I am an adult of sound mind. I am suffering from an incurable, irreversible terminal disease that my attending qualified medical provider determined will result in death within six months.

Name of terminal disease: _____

My attending qualified medical provider fully informed me 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 qualified medical provider prescribe medication that I may self-administer to end my life in a humane and dignified manner and dispense or contact a pharmacist to dispense the prescription.

Initial only one of the next three statements.

- 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 fully understand the meaning and importance of this request, and I expect to die when I take the prescribed medication. I further understand that although most deaths occur within three hours, my death may take longer and my qualified medical provider explained 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: _____

Declaration Of Witnesses

By initialing and signing below in the presence of the person named above, we declare that the person making and signing the above request:

	Witness 1	Witness 2
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 qualified medical provider.	_____	_____

Witness 1
Printed Name: _____ Signature: _____ Date: _____

Witness 2
Printed Name: _____ Signature: _____ Date: _____