PATIENT REQUEST FOR MEDICAL ASSISTANCE IN DYING (MAID)

If you wish to request medical assistance in dying (MAID), complete this form and give it to your regular health-care provider.

For more information about MAID, speak to your health-care provider or visit www.yukon.ca/MAID.

You have the right to withdraw this request for medical assistance in dying at any time.

A. Patient Information		
Last name	First name	Middle name
Date of birth (DD/MM/YYYY)	Health care insurance number	Province or territory of issue
Medical diagnosis and concerns leading to your request for medical assistance in dying		

B. Patient criteria and signature	
I am requesting medical assistance in dying and I meet **all** of the following criteria: • I have a serious and incurable illness, disease or disability. • I am in an advanced state of irreversible decline in capability. • I am enduring physical or psychological suffering as a result of the illness, disease, disability or that state of decline, which cannot be relieved under conditions I consider acceptable.	
Patient or proxy* signature	Date (DD/MM/YYYY)

***** A **proxy** is a person acting on behalf of the patient. A proxy may initial, sign and date this record on the patient's behalf **only if**:

a. the proxy is in the presence of the patient;
b. the patient has given the proxy an express direction to sign and date this form on their behalf because the patient is physically unable to do so;
c. the proxy is at least 18 years old;
d. the proxy understands the nature of the request for medical assistance in dying;
e. the proxy does not know or believe that they are a beneficiary under the will of the patient, or will be a recipient in any other way of a financial or other material benefit resulting from the patient's death; and
f. the proxy is not also signing and dating this record as an independent witness.

Please note that a witness signature is required. See page 2 of this form.

C. Declaration of independent witness

By **initialing** and **signing** below, I declare that I am at least 18 years of age and understand the nature of the request for medical assistance in dying. I also declare that:

_____ I neither know nor believe that I am a beneficiary under the will of the patient or a recipient in any other way of a financial or material benefit resulting from the patient's death.

_____ I am not an owner or operator of a health-care facility where the patient is receiving treatment or of a facility in which the patient resides.

_____ I am not directly involved in providing **unpaid** health or personal care services to the patient.

_____ I am not the medical practitioner or nurse practitioner who will perform medical assistance in dying; nor am I the medical practitioner or nurse practitioner who has provided a written opinion on the patient's eligibility for medical assistance in dying.

_____ **The patient signed and dated this request in my presence**; or if the patient was unable to do so, the patient's proxy signed and dated this request on the patient's behalf in my presence and in the presence of the patient under the express direction of the patient.

Witness printed name	Date (DD/MM/YYYY)
Witness signature	