



**Medical Assistance in Dying
REQUEST FOR
MEDICAL ASSISTANCE IN DYING**

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Requestor: submit this form to your doctor or nurse practitioner, or MAiD Care Coordination Service.
Practitioner: if required, fax or mail a **COPY** of this form to the applicable health authority MAiD CCS.
See bottom of page 2 for MAiD Care Coordination Service contact information.

REQUESTOR INFORMATION

Last Name		First Name		Second Name(s)	
Personal Health Number (PHN) <input type="checkbox"/> N/A		Birthdate (YYYY / MM / DD)		Gender <input type="radio"/> Male <input type="radio"/> X (specify) <input type="radio"/> Female	
Requestor's Home / Residence Address		City		Postal Code	
				Phone Number	
Medical Diagnosis Relevant to Request for Medical Assistance in Dying					
Primary Health Care Provider (Name)				Phone Number	
Contacted Person(s) for Health Care Providers <input type="checkbox"/> Myself and/or <input type="checkbox"/> Preferred Contact →		Preferred Contact Name		Relationship	
				Preferred Contact Phone Number	

PROFESSIONAL INTERPRETER (PROVINCIAL LANGUAGE SERVICE OR OTHER) IF USED

Last Name		First Name		ID Number		Date of Service (YYYY / MM / DD)	
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MY REQUEST – by initialing and signing below, I confirm that:

Initials	I request medical assistance in dying. I make this request voluntarily, without pressure from others and expect to die when the prescribed medication is administered.
Initials	I have been informed by a medical practitioner that I have an incurable illness, disease or disability.
Initials	I believe that my medical condition is serious and cannot be cured by any means I accept.
Initials	Where required by law, I understand that my information will be shared with other health professionals directly involved in my care.
Initials	I can and have the right to change my mind and to ask questions at any time.
Initials	I understand that it is my responsibility to seek advice on my life insurance policy.

REQUESTOR SIGNATURE (must be signed in front of the independent witness listed on page 2)

***A proxy may sign for you if you are physically unable to sign the request. The proxy cannot be the same person as the witness on page 2.**

Signature of Requestor		Print Name		Date Signed (YYYY / MM / DD)	
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PROXY SIGNATURE (IF APPLICABLE) (must be signed in the physical presence the requestor and in front of independent witness on the same date)

By signing below as the proxy on behalf of the requestor, I confirm that:

- I am at least 18 years of age
- I understand the nature of the 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 the person's death.
- I signed this request for MAiD in the presence of the person making the request, on their behalf and under their express direction.

Signature of Proxy		Print Name		Relationship to Requestor		
		Date Signed (YYYY / MM / DD)		Phone Number		
Address			City		Province	
					Postal Code	

Last Name of Requestor		First Name of Requestor		Second Name(s) of Requestor	
CONFIRMATION OF INDEPENDENT WITNESS					
By initialing and signing below, I confirm that:					
Witness					
Initials	a. I am at least 18 years of age and understand the nature of the request for medical assistance in dying.				
Initials	b. The requestor is personally known to me or has provided proof of identity.				
Initials	c. The requestor (or the proxy in the presence and at the express direction of the requestor) signed this request in my presence.				
Initials	d. I do not know or believe that I am a beneficiary under the will of the requestor, or a recipient, in any other way, of a financial or material benefit resulting from the requestor's death.				
Initials	e. I am not an owner or operator of a health care facility where the requestor is receiving treatment or in which the requestor resides.				
Initials	f. I am not directly involved in providing health care services to the requestor.*				
Initials	g. I do not directly provide personal care to the requestor.*				
Initials	h. I provide paid personal care or health care services to requestor as my primary occupation and I am not the assessor, prescriber or consultant involved in the requestor's assessment for MAiD; therefore I did not initial f and/or g above.				
* A witness is still considered independent if they provide health care services or personal care to the requestor as their primary occupation and are paid to do so, and are not the assessor, prescriber, or consultant involved in the requestor's assessment for MAiD.					
SIGNATURE OF INDEPENDENT WITNESS (must be signed in the presence of the requestor and on the same date)					
Signature of Witness		Print Name		Relationship to Requestor	
		Date Signed (YYYY / MM / DD)		Phone Number	
Address			City		Province Postal Code

Please ensure all of the boxes above are completed. To proceed with an assessment of eligibility, submit this form to your physician or nurse practitioner, or contact your health authority's care coordination service for medical assistance in dying (contact information below). Please keep a copy of your request for your records.

Health Authority MAiD Care Coordination Service phone and fax numbers for submission of forms:

For mailing addresses of Health Authorities, see:

<https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/forms>

Fraser Health Authority	Phone: 604-587-7878, Fax: 604-523-8855, Email: mccc@fraserhealth.ca https://www.fraserhealth.ca/Service-Directory/Services/end-of-life/medical-assistance-in-dying
Interior Health Authority	Phone: 1-844-469-7073, Fax: 250-469-7066, Email: maid@interiorhealth.ca https://www.interiorhealth.ca/YourCare/MAiD
Northern Health Authority	Phone: 250-645-8549, Fax: 250-565-2640, Email: maid@northernhealth.ca https://www.northernhealth.ca/health-topics/medical-assistance-dying-maid
Vancouver Coastal Health Authority	Phone: 1-844-550-5556, Fax: 1-888-865-2941, Email: AssistedDying@vch.ca http://www.vch.ca/assisted-dying
Vancouver Island Health Authority	Phone: 1-877-370-8699, Fax: 250-519-3669, Email: maid@viha.ca https://www.islandhealth.ca/learn-about-health/medical-assistance-dying/medical-assistance-dying
Provincial Health Services Authority	Phone: 1-888-875-3256, Fax: 604-829-2631, Email: maidcco@psha.ca http://www.psha.ca/health-info/medical-assistance-in-dying