§ 2899-k. Form of written request and witness attestation. 1. A request for medication under this article shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE

I, _____, am an adult who has decision-making capacity, which means I understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision and to communicate health care decisions to a physician.

I have been diagnosed with (insert diagnosis), which my attending physician has determined is a terminal illness or condition, which has been medically confirmed by a consulting physician and mental health professional and will, in the judgment of the physicians and mental health professional, produce death within six months whether or not treatment is provided.

I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives and treatment options including but not limited to palliative care and hospice care.

I request that my attending physician prescribe medication that will end my life if I choose to take it, and I authorize my attending physician to contact another physician or any pharmacist about my request.

INITIAL ONE:

( ) I have informed or intend to inform one or more members of my family of my decision.

( ) I have decided not to inform any member of 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 or decline

to use the medication at any time.

I understand the importance of this request, and I expect to die if 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 attending physician has counseled me about this possibility.

I make this request voluntarily, of my own volition and without being coerced, and I accept full responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

I declare that the person signing this "Request for Medication to End My Life":

(a) is personally known to me or has provided proof of identity;

(b) voluntarily signed the "Request for Medication to End My Life" in my presence or acknowledged to me that the person signed it; and

(c) to the best of my knowledge and belief, has decision-making capacity and is making the "Request for Medication to End My Life" voluntarily, of the person's own volition and is not being coerced to sign the "Request for Medication to End My Life".

I am not the attending physician or consulting physician of the person signing the "Request for Medication to End My Life" or the mental health professional who provides a decision-making capacity determination of the person signing the "Request for Medication to End My Life" at the time the "Request for Medication to End My Life" was signed.

I further declare under penalty of perjury that the statements made herein are true and correct and false statements made herein are punishable.

I further declare that I am not (i) related to the above-named patient by blood, marriage or adoption; (ii) entitled at the time the patient signed the "Request for Medication to End My Life" to any portion of the estate of the patient upon such patient's death under any will or by

operation of law, or otherwise in a position to benefit financially from the patient's death; (iii) an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a resident; (iv) a domestic partner of the patient, as defined in subdivision seven of section twenty-nine hundred ninety-four-a of the public health law; (v) an agent, as defined in subdivision five of section twenty-nine hundred eighty of the public health law, under the patient's health care proxy; or (vi) an agent, as defined in section 5-1501 of the general obligations law, acting under a power of attorney for the patient.

Witness 1, Date:

(Printed name)

(Address)

(Telephone number)

Witness 2, Date:

(Printed name)

(Address)

(Telephone number)

2. (a) The "Request for Medication to End My Life" shall be written in the same language as any conversations, consultations, or interpreted conversations or consultations between a patient and at least one of the patient's attending or consulting physicians.

(b) Notwithstanding paragraph (a) of this subdivision, the written "Request for Medication to End My Life" may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English or with auxiliary aids or hearing, speech or visual aids, if the English language form includes an attached declaration by the interpreter of the conversation or consultation, which shall be in substantially the following form:

INTERPRETER'S DECLARATION

I, (insert name of interpreter), (mark as applicable):

( ) for a patient whose conversations or consultations or interpreted conversations or consultations were conducted in a language other than English and the "Request for Medication to End My Life" is in English: I

declare that I am fluent in English and (insert target language). I have the requisite language and interpreter skills to be able to interpret effectively, accurately and impartially information shared and communications between the attending or consulting physician and (name of patient).

I certify that on (insert date), at approximately (insert time), I interpreted the communications and information conveyed between the physician and (name of patient) as accurately and completely to the best of my knowledge and ability and read the "Request for Medication to End My Life" to (name of patient) in (insert target language).

(Name of patient) affirmed to me such patient's desire to sign the "Request for Medication to End My Life" voluntarily, of (name of patient)'s own volition and without coercion.

() for a patient with a speech, hearing or vision disability: I declare that I have the requisite language, reading and/or interpreter skills to communicate with the patient and to be able to read and/or interpret effectively, accurately and impartially information shared and communications that occurred on (insert date) between the attending or consulting physician and (name of patient).

I certify that on (insert date), at approximately (insert time), I read and/or interpreted the communications and information conveyed between the physician and (name of patient) impartially and as accurately and completely to the best of my knowledge and ability and, where needed for effective communication, read or interpreted the "Request for Medication to End my Life" to (name of patient).

(Name of patient) affirmed to me such patient's desire to sign the "Request for Medication to End My Life" voluntarily, of (name of patient)'s own volition and without coercion.

I further declare under penalty of perjury that (i) the foregoing is true and correct; (ii) I am not (A) related to (name of patient) by blood, marriage or adoption; (B) entitled at the time (name of patient) signed the "Request for Medication to End My Life" to any portion of the estate of (name of patient) upon such patient's death under any will or by operation of law, or otherwise in a position to benefit financially

from the patient's death; (C) an owner, operator, employee or independent contractor of a health care facility where (name of patient) is receiving treatment or is a resident, except that if I am an employee or independent contractor at such health care facility, providing interpreter services is part of my job description at such health care facility or I have been trained to provide interpreter services and (name of patient) requested that I provide interpreter services to such patient for the purposes stated in this Declaration; (D) a domestic partner of the patient, as defined in subdivision seven of section twenty-nine hundred ninety-four-a of the public health law; (E) an agent, as defined in subdivision five of section twenty-nine hundred eighty of the public health law, under the patient's health care proxy; or (F) an agent, as defined in section 5-1501 of the general obligations law, acting under a power of attorney for the patient; and (iii) false statements made herein are punishable.

Executed at (insert city, county and state) on this (insert day of month) of (insert month), (insert year).

(Signature of Interpreter)

(Printed name of Interpreter)

(ID # or Agency Name)

(Address of Interpreter)

(Language Spoken by Interpreter)

(c) An interpreter whose services are provided under paragraph (b) of this subdivision shall not (i) be related to the patient who signs the "Request for Medication to End My Life" by blood, marriage or adoption; (ii) be entitled at the time the "Request for Medication to End My Life" is signed by the patient to any portion of the estate of the patient upon death under any will or by operation of law, or otherwise in a position to benefit financially from the patient's death; (iii) be an owner, operator, employee or independent contractor of a health care facility where the patient is receiving treatment or is a resident; provided that an employee or independent contractor whose job description at the health care facility includes interpreter services or who is trained to provide interpreter services and who has been requested by the patient to serve as an interpreter under this article shall not be prohibited from serving as an interpreter under this article; (iv) be a domestic partner of the patient, as defined in

subdivision seven of section twenty-nine hundred ninety-four-a of this chapter; (v) be an agent, as defined in subdivision five of section twenty-nine hundred eighty of this chapter, under the patient's health care proxy; or (vi) be an agent, as defined in section 5-1501 of the general obligations law, acting under a power of attorney for the patient.