RCW 70.245.220 Form of the request. A request for a medication as authorized by this chapter shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, ..., am an adult of sound mind.

I am suffering from . . . . . ., which my attending qualified medical provider has determined is a terminal disease that will result in death within six months.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the 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 to contact any pharmacist to fill the prescription.

INITIAL ONE:

. . . . . 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 understand the full import of this request and I expect to die when 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 qualified medical provider has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: . . . . . .

Dated: . . . . . .

DECLARATION OF WITNESSES

By initialing and signing below on or after the date the person named above signs, we declare that the person making and signing the above request:

Witness 1 Initials	Witness 2 Initials	
.....	.....	1. Is personally known to us or has provided proof of identity;
.....	.....	2. Signed this request in our presence on the date of 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.

Printed Name of Witness 1:. . . . . .

Signature of Witness 1/Date:. . . . . .

Printed Name of Witness 2:. . . . . .

Signature of Witness 2/Date:. . . . . .

NOTE: One witness shall not be a relative by blood, marriage, or adoption of the person signing this request, shall not be entitled to any portion of the person's estate upon death, and shall not own, operate, or be employed at a health care facility where the person is a patient or resident. [2023 c 38 § 17; 2009 c 1 § 22 (Initiative Measure No. 1000, approved November 4, 2008).]