MEDICAL ASSISTANCE IN DYING (MAiD)#
AFFIRMATION FORM

Patient Name: _____ **DOB:** _____ **HCN:** _____

Address: _____

Physician Name: _____ **Telephone Number:** _____

I affirm that:

a) The patient is eligible for publicly-funded health care services in Canada;

b) The patient is at least 18 years of age and capable of making decisions with respect to their health;

c) The patient has, according to Bill C-14, a grievous and irremediable medical condition (including an illness, disease or disability) which means the patient(‘s):

- has a serious and incurable illness, disease or disability, and
- is in an advanced state of irreversible decline in capability, and
- is enduring physical or psychological suffering, caused by the illness, disease or disability or that state of decline, that is intolerable to the person and that cannot be relieved under conditions that they consider acceptable, and
- natural death has become reasonably foreseeable;

d) The patient made a voluntary request for MAiD that is not the result of external pressure; and

e) The patient provided informed consent to receive MAiD.

Physician signature confirms that the patient meets the eligibility criteria as above and that all safeguards identified have been met.

Physician’s Name: _____ **Date:** _____

Physician’s Signature: _____

Pharmacist’s Name: _____ **Date:** _____

Pharmacist’s Signature: _____