Newfoundland Labrador

CN3100 0051 02 2023

Medical Assistance in Dying (MAiD)
Waiver of Final Consent Agreement

First Name:	Last Name:	
HCN:	Date of Birth (YYYY/MON/DD):	

Patient Section

Persons whose natural death has become reasonably foreseeable may complete a written **Waiver of Final Consent Agreement** for MAiD to take place on a particular date under the following conditions:

- This written arrangement will be made with the person and the physician or nurse practitioner who has assessed the person and is scheduled to perform the MAiD procedure.
- This option is available for persons who:
  - have been assessed and approved for MAiD;
  - have indicated their preferred date for their MAiD procedure; and
  - are at risk of losing decision-making capacity prior to their scheduled MAiD procedure.

By checking the boxes and signing below, I confirm that:

☐ I am requesting a MAiD procedure on (YYYY/MON/DD):

☐ I have been informed by my MAiD provider that I am at risk of losing capacity to give final consent for my MAiD procedure.

☐ I request that my MAiD Provider complete my MAiD procedure on or before the date indicated above if I have lost capacity to consent to MAiD on or before that time.

☐ I understand that if, on or before the date indicated above, I demonstrate by words, sounds or gestures, purposeful refusal or resistance to the administration of a substance that would cause my death, the **Waiver of Final Consent Agreement** will be invalidated, and that the MAiD procedure will not be performed.

Signature of the Patient:	Print Name:	Date (YYYY/MON/DD):

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If the person requesting MAiD is physically unable to sign and date this request, another person (a proxy) may do so in the person's presence, on the person's behalf and under the person's express direction.

Proxy Signature

☐ I am at least 18 years of age.

☐ I understand the nature of this person's request for MAiD.

☐ I am not a beneficiary under the Will of the person making this request for MAiD, or a recipient in any other way of financial or other material benefit resulting from that person's death

☐ I am signing this document on behalf of _____ in their presence and under their express direction.

Signature of Proxy: _____ Print Name: _____ Date (YYYY/MON/DD): _____

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____ Telephone: _____

Physician/Nurse Practitioner Section

☐ I have advised _____ that they are at risk of losing capacity to give final consent to MAiD.

☐ _____ has requested a MAiD procedure on (YYYY/MON/DD): _____ and I have agreed to provide MAiD on or before that date, even if they have lost capacity to consent to MAiD.

Physician/Nurse Practitioner Signature

Signature of Health Care Practitioner: _____ Print Name: _____ Date (YYYY/MON/DD): _____

Return a copy of this form to the Regional MAiD Coordinator no later than 30 days after MAiD is delivered.

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