New Jersey Department of Health

MEDICAL AID IN DYING FOR THE TERMINALLY ILL ACT
ATTENDING PHYSICIAN COMPLIANCE FORM

Filing Instructions:

1. Must be completed by the attending physician who determined whether the person was a "qualified terminally ill patient" and met the other legal requirements for receiving medication under the Medical Aid in Dying Act (P.L.2019, c.59).
2. Under P.L.2019, c.59, this form must be filed as soon as possible and no later than 30 days after the date of the qualified terminally ill patient's death.
3. Forms shall be filed with the New Jersey Office of the Chief State Medical Examiner at:
   PO Box 182
   Trenton, NJ 08625
   Or you may submit your documents and your digitally signed forms via email to OCSME staff at maid@doh.nj.gov.
4. **The following forms must be appended for this form to be complete:**
   (1) Copy of the Request for Medication to End My Life in a Humane and Dignified Manner
   (2) Consulting Physician Compliance Form
   (3) Mental Health Professional Compliance Form (if applicable)
5. After a patient's death and submission of these materials, the New Jersey Office of the Chief State Medical Examiner will contact the listed attending physician with follow-up questions necessary for appropriate death certificate filing.

Date of Report Mailing: _____
[Month/Day/Year]

PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*
Patient's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	

ATTENDING PHYSICIAN INFORMATION			
Physician's Name:	*[Last Name, First Name, Middle Name]*	Physician's Telephone Number:	*[10-digit]*
Physician's Facility Name:			
Physician's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Physician's License Number:			

CONSULTING PHYSICIAN INFORMATION			
Physician's Name:	*[Last Name, First Name, Middle Name]*	Physician's Telephone Number:	*[10-digit]*
Physician's Facility Name:			
Physician's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Physician's License Number:			

Blank forms available at: http://nj.gov/health/maid

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PATIENT ELIGIBILITY DETERMINATION

PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*

Terminal Illness, Disease, or Condition:

_____

CHECK ALL THAT APPLY:

- ☐ Made the initial determination of whether a patient is terminally ill, is capable, and has voluntarily made the request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.).
- ☐ Required that the patient demonstrate New Jersey residency pursuant to section 11 of P.L.2019, c.59 (C.26:16-11).
- ☐ Informed the patient of all of the following:
  1. The patient's medical diagnosis and prognosis.
  2. The potential risks associated with taking the medication to be prescribed.
  3. The probable result of taking the medication to be prescribed.
  4. The feasible alternatives to taking the medication, including, but not limited to, concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control.
- ☐ Referred the patient to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the patient is capable and acting voluntarily.
- ☐ Referred the patient to a mental health care professional or determined that such a referral is not appropriate, pursuant to section 8 of P.L.2019, c.59 (C.26:16-8).
- ☐ Recommended that the patient participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options for the patient, and provided the patient with a referral to a health care professional qualified to discuss these options with the patient.
- ☐ Advised the patient about the importance of having another person present if and when the patient chooses to self-administer medication prescribed under P.L.2019, c.59 (C.26:16-1 et al.) and of not taking the medication in a public place.
- ☐ Informed the patient of the patient's opportunity to rescind the request at any time and in any manner.
- ☐ Offered the patient an opportunity to rescind the request at the time the patient made a second oral request as provided in section 10 of P.L.2019, c.59 (C.26:16-10).
- ☐ Fulfilled the medical record documentation requirements of P.L.2019, c.59 (C.26:16-1 et al.).

Requests for Medication:

First Oral Request Date: _____ *[Month/Day/Year]* Time of Request: _____ *[12-Hour Format AM/PM*

Written Request Submission Date: _____ *[Month/Day/Year]* Time of Request: _____ *[12-Hour Format AM/PM]*

Second Oral Request Date: _____ *[Month/Day/Year]* Time of Request: _____ *[12-Hour Format AM/PM*

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PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*

Patient's Mental Status:

CHECK ONE:

☐ In my medical opinion, the patient requesting medication is capable.
☐ In my medical opinion, the patient may not be capable. I subsequently referred the patient to a mental health care professional (listed below) who notified me in writing that that mental health care professional determined that the patient is capable.

MENTAL HEALTH PROFESSIONAL'S INFORMATION			
Professional's Name:	*[Last Name, First Name, Middle Name]*	Professional's Telephone Number:	*[10-digit]*
Professional's Facility Name:			
Professional's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	
Professional's License Number:			

DISPENSING HEALTH CARE PROVIDER INFORMATION *The attending physician may dispense medication(s) directly, if the attending physician is authorized under law to dispense and has a current federal DEA certificate of registration, or contact a pharmacist who shall dispense the medication in accordance with P.L. 2019, c.59.*			
Provider's Name:	*[Last Name, First Name, Middle Name]*	Provider's Telephone Number:	*[10-digit]*
Provider's Mailing Address:	*[Street Address]*	*[City, State, Zip Code]*	

MEDICATION PRESCRIBED		
Medication Name	Quantity	Date Prescribed *[Month/Day/Year]*

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PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*

MEDICATION PRESCRIBED CONTINUED		
Medication Name	Quantity	Date Prescribed *[Month/Day/Year]*

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PATIENT INFORMATION			
Patient's Name:	*[Last Name, First Name, Middle Name]*	Patient's Date of Birth:	*[Month/Day/Year]*

CHECK ONE

Method prescription was delivered to a pharmacist:

- ☐ In person.
- ☐ By Permissible Electronic Communication.
- ☐ By Mail.
- ☐ Not applicable. I directly dispensed the medication.

AUTHORIZATION

Signature: _____ Date: _____
[Month/Day/Year]