MEDICAL ASSISTANCE IN DYING (MAiD) - WAIVER OF FINAL CONSENT

MAiD Case #:	First Name:	Last Name:
Health Card Number:	Date of Birth (YYYY/MON/DD):	

1. Introduction

Persons who are eligible for MAiD and whose natural death has become reasonably foreseeable may complete a written **Waiver of Final Consent** (hereafter known as the 'Waiver') that will allow MAiD to take place on or before a pre-specified date if they have lost the capacity to consent to receive MAiD.

The Waiver may be completed *before* both MAiD assessments have been completed. However, the person requesting the Waiver *must* have met all MAiD eligibility criteria as determined by the two independent assessors before the Waiver can be acted upon.

The Waiver is an agreement between the person requesting MAiD and a specific MAiD provider named in the Waiver. An alternative MAiD provider may also be named in case the first provider is unavailable to provide MAiD on or before the pre-specified date.

2. Person Requesting MAiD Section

By signing below, I confirm that:

- I have been informed by my MAiD provider that I am at risk of losing the capacity to consent to receive MAiD prior to the day specified in this Waiver.
- I request that MAiD be provided on the following date: _____ (YYYY/MON/DD).
- I consent to the administration of medications that will cause my death by my MAiD provider on or before the following date: _____ (YYYY/MON/DD) if I have lost the capacity to consent to receive MAiD on or before that date.
- I understand that I may withdraw my request for MAiD at any time going forward as long as I continue to have the capacity to make decisions about MAiD. This includes cancelling my MAiD provision entirely, or revoking this Waiver, and/or creating a new Waiver for some future date.
- I understand that if I lack the capacity to consent to receive MAiD at the time of the MAiD provision, but demonstrate by words, sounds, or gestures a refusal of or resistance to the administration of MAiD, that this Waiver will be invalidated, and MAiD will not be provided to me. I also understand that involuntary words, sounds, or gestures made in response to physical contact at the time of the MAiD provision do not constitute a demonstration of refusal or resistance to the administration of MAiD.

Printed Name of Person requesting MAiD:	Signature of Person requesting MAiD:	Date (YYYY/MON/DD):

3. Proxy Section - to be completed if the person making the MAiD request is not physically able to sign this form

By signing below I confirm that:

- I am at least 18 years of age.
- I understand the nature of: _____ (insert name of person) request for MAiD.
- I do not know or believe that I am a beneficiary under the Will of: _____ (insert name of person) or a recipient, in any other way, of a financial or other material benefit resulting from their death.
- I am signing this document on behalf of: _____ (insert name of person) in their presence and under their express direction.

Printed Name of Proxy Signer:	Signature of Proxy Signer:	Date (YYYY/MON/DD):

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4. MAiD Provider Section

_____ (insert name of patient) has requested a MAiD provision on the following date: _____ (YYYY/MON/DD).

I have advised: _____ (insert name of patient) that they are at risk of losing the capacity to give express consent prior to the provision of MAiD on or before the date specified above.

By signing below, I agree to provide MAiD to: _____ (insert name of patient) on or before the date specified above. At the time of the MAiD provision, I will confirm that:

- _____ (insert name of patient) has lost the capacity to give express consent to the provision of MAiD.
- _____ (insert name of patient) met all the eligibility criteria and procedural safeguards for MAiD before they lost the capacity to consent to receive MAiD.

I have informed: _____ (insert name of patient) that if I am not able to provide MAiD on or before the date specified above that the alternate MAiD provider named below will be contacted.

Printed Name of MAiD Provider:	Signature of MAiD Provider:	Date (YYYY/MON/DD):

5. Alternate MAiD Provider Section

_____ (insert name of patient) has requested a MAiD provision on the following date: _____ (YYYY/MON/DD).

I have informed: _____ (insert name of patient) that if the above-named MAiD provider is not able to provide MAiD on or before the date specified above, I will act on their behalf.

I have advised: _____ (insert name of patient) that they are at risk of losing the capacity to give express consent prior to the provision of MAiD on or before the date specified above.

By signing below, I agree to provide MAiD to: _____ (insert name of patient) on or before the date specified above. At the time of the MAiD provision, I will confirm that:

- _____ (insert name of patient) has lost the capacity to give express consent to the provision of MAiD.
- _____ (insert name of patient) met all the eligibility criteria and procedural safeguards for MAiD before they lost the capacity to consent to receive MAiD.

Printed Name of MAiD Provider:	Signature of MAiD Provider:	Date (YYYY/MON/DD):