DEATH WITH DIGNITY

State Statute Navigator

This document contains the contents of Death with Dignity's online, searchable statute navigator. This information is based on the most current versions of each statute and will be updated after laws are amended or new laws pass. This document is intended as a resource only, and we have included direct links below to the published laws for your convenience. Please refer directly to state statutes to quote, cite, or otherwise reference the laws.

California

443. (Short Title)	This part shall be known and may be cited as the End of Life Option Act. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.1. (Definitions)	As used in this part, the following definitions shall apply:

(a) “Adult” means an individual 18 years of age or older.
(b) “Aid-in-dying drug” means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death due to a terminal disease.
(c) “Attending physician” means the physician who has primary responsibility for the health care of an individual and treatment of the individual’s terminal disease.
(d) “Attending physician checklist and compliance form” means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.
(e) “Capacity to make medical decisions” means that, in the opinion of an individual’s attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.
(f) “Consulting physician” means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual’s terminal disease.
(g) “Department” means the State Department of Public Health.
(h) “Health care provider” or “provider of health care” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; and any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code.
(i) “Health care entity” means any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200), including a general hospital, medical clinic, nursing home or hospice facility. A health care entity does not include individuals described in subdivision (h).
(j) “Informed decision” means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual’s life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:
(1) The individual’s medical diagnosis and prognosis.
(2) The potential risks associated with taking the drug to be prescribed.
(3) The probable result of taking the drug to be prescribed.
(4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.
(5) The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.
(k) “Medically confirmed” means the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual’s relevant medical records.
(l) “Mental health specialist assessment” means one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not

	suffering from impaired judgment due to a mental disorder. (m) “Mental health specialist” means a psychiatrist or a licensed psychologist. (n) “Physician” means a doctor of medicine or osteopathy currently licensed to practice medicine in this state. (o) “Public place” means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access. “Public place” does not include a health care entity. (p) “Qualified individual” means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end their life. (q) “Self-administer” means a qualified individual’s affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about their own death. (r) “Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months. (Amended by Stats. 2021, Ch. 542, Sec. 1. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.2. (Residency and Other Conditions)	(a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied: (1) The individual’s attending physician has diagnosed the individual with a terminal disease. (2) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug. (3) The individual is a resident of California and is able to establish residency through any of the following means: (A) Possession of a California driver’s license or other identification issued by the State of California. (B) Registration to vote in California. (C) Evidence that the person owns or leases property in California. (D) Filing of a California tax return for the most recent tax year. (4) The individual documents his or her request pursuant to the requirements set forth in Section 443.3. (5) The individual has the physical and mental ability to self-administer the aid-in-dying drug. (b) A person shall not be considered a “qualified individual” under the provisions of this part solely because of age or disability. (c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker. (Amended by Stats. 2017, Ch. 561, Sec. 99. (AB 1516) Effective January 1, 2018. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.3. (Form of	(a) An individual seeking to obtain a prescription for an aid-in-dying drug pursuant to this part shall submit two oral

Request)	requests, a minimum of 48 hours apart, and a written request to their attending physician. An attending physician shall directly, and not through a designee, receive a request required pursuant to this section and shall ensure the date of a request is documented in an individual's medical record. An oral request documented in an individual's medical record shall not be disregarded by an attending physician solely because it was received by a prior attending physician or an attending physician who chose not to participate. (b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions: (1) The request shall be in the form described in Section 443.11. (2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug. (3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following: (A) An individual who is personally known to them or has provided proof of identity. (B) An individual who voluntarily signed this request in their presence. (C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence. (D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist. (c) Only one of the two witnesses at the time the written request is signed may: (1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death. (2) Own, operate, or be employed at a health care entity where the individual is receiving medical treatment or resides. (d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b). (Amended by Stats. 2021, Ch. 542, Sec. 2. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.4. (Right to Rescind)	(a) An individual may at any time withdraw or rescind their request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state. (b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request. (c) If the individual decides to transfer care to another physician, upon request of the individual the physician shall transfer all relevant medical records including written documentation including the dates of the individual's oral and written requests seeking to obtain a prescription for an aid-in-dying drug. (Amended by Stats. 2021, Ch. 542, Sec. 3. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.5. (Attending)

(a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:

(1) Make the initial determination of all of the following:

(A) (i) Whether the requesting adult has the capacity to make medical decisions.

(ii) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.

(iii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(B) Whether the requesting adult has a terminal disease.

(C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.

(D) Whether the requesting adult is a qualified individual pursuant to subdivision (q) of Section 443.1.

(2) Confirm that the individual is making an informed decision by discussing with them all of the following:

(A) Their medical diagnosis and prognosis.

(B) The potential risks associated with ingesting the requested aid-in-dying drug.

(C) The probable result of ingesting the aid-in-dying drug.

(D) The possibility that they may choose to obtain the aid-in-dying drug but not take it.

(E) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.

(4) Confirm that the qualified individual’s request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.

(5) Counsel the qualified individual about the importance of all of the following:

(A) Having another person present when they ingest the aid-in-dying drug prescribed pursuant to this part.

(B) Not ingesting the aid-in-dying drug in a public place.

(C) Notifying the next of kin of their request for an aid-in-dying drug. A qualified individual who declines or is unable to notify next of kin shall not have their request denied for that reason.

(D) Participating in a hospice program.

(E) Maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.

(6) Inform the individual that they may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner.

(7) Offer the individual an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing

the aid-in-dying drug.

(8) Verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision.

(9) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.

(10) Fulfill the record documentation required under Sections 443.8 and 443.19.

(11) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.

(b) If the conditions set forth in subdivision (a) are satisfied, the attending physician may deliver the aid-in-dying drug in any of the following ways:

(1) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician meets all of the following criteria:

(A) Is authorized to dispense medicine under California law.

(B) Has a current United States Drug Enforcement Administration (USDEA) certificate.

(C) Complies with any applicable administrative rule or regulation.

(2) With the qualified individual's written consent, contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.

(c) Delivery of the dispensed drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual may be made by personal delivery, or, with a signature required on delivery, by United Parcel Service, United States Postal Service, FedEx, or by messenger service.

(Amended by Stats. 2021, Ch. 542, Sec. 4. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.6. (Consulting)

Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:

(a) Examine the individual and his or her relevant medical records.

(b) Confirm in writing the attending physician's diagnosis and prognosis.

(c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.

(d) If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.

(e) Fulfill the record documentation required under this part.

(f) Submit the compliance form to the attending physician.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1,

	2031, pursuant to Section 443.215.)
443.7. (Capacity Referral)	Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall: (a) Examine the qualified individual and his or her relevant medical records. (b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision. (c) Determine that the individual is not suffering from impaired judgment due to a mental disorder. (d) Fulfill the record documentation requirements of this part. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.8. (Documentation)	All of the following shall be documented in the individual's medical record: (a) All oral requests for aid-in-dying drugs. (b) All written requests for aid-in-dying drugs. (c) The attending physician's diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual. (d) The consulting physician's diagnosis and prognosis, and verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual. (e) A report of the outcome and determinations made during a mental health specialist's assessment, if performed. (f) The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request. (g) A note by the attending physician indicating that all requirements under Sections 443.5 and 443.6 have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.9. (Reporting)	(a) Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient's written request, the attending physician checklist and compliance form, and the consulting physician compliance form. (b) Within 30 calendar days following the qualified individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician followup form to the State Department of Public Health. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.10. (Informed Decision)	A qualified individual may not receive a prescription for an aid-in-dying drug pursuant to this part unless he or she has made an informed decision. Immediately before writing a prescription for an aid-in-dying drug under this part, the attending physician shall verify that the individual is making an informed decision. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.11. (Form of Request)	*** Refer directly to statute for form of patient written request. ***
443.12. (Contracts, Wills)	(a) A provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug is not valid. (b) An obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.13. (Insurance)	(a) (1) The sale, procurement, or issuance of a life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for an aid-in-dying drug. (2) Pursuant to Section 443.18, death resulting from the self-administration of an aid-in-dying drug is not suicide, and therefore health and insurance coverage shall not be exempted on that basis. (b) Notwithstanding any other law, a qualified individual's act of self-administering an aid-in-dying drug shall not have an effect upon a life, health, or annuity policy other than that of a natural death from the underlying disease. (c) An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. For the purposes of this subdivision, "insurance carrier" means a health care service plan as defined in Section 1345 of this code or a carrier of health insurance as defined in Section 106 of the Insurance Code. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.14. (Liabilities)	(a) Notwithstanding any other law, a person shall not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. A person who is present

may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug.
(b) A health care provider, health care entity, or professional organization or association shall not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with this part or for refusing to participate in accordance with subdivision (e).
(c) Notwithstanding any other law, a health care provider or a health care entity shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in this part. This subdivision does not limit the application of, or provide immunity from, Section 443.15, 443.16, or 443.17.
(d) (1) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this part shall not provide the sole basis for the appointment of a guardian or conservator.

(2) Actions taken in compliance with the provisions of this part shall not constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.
(e) (1) Participation under this part shall be voluntary. Notwithstanding Sections 442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality, or ethics, not to participate is not required to participate under this part. This subdivision does not limit the application of, or excuse noncompliance with, paragraphs (2), (4), and (5) of this subdivision or subdivision (b), (i), or (j) of Section 443.15, as applicable.

(2) A health care provider who objects for reasons of conscience, morality, or ethics to participate under this part shall not be required to participate. If a health care provider is unable or unwilling to participate under this part, as defined in subdivision (f) of Section 443.15, the provider shall, at a minimum, inform the individual that they do not participate in the End of Life Option Act, document the individual's date of request and provider's notice to the individual of their objection in the medical record, and transfer the individual's relevant medical record upon request.

(3) A health care provider or health care entity is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate under this part, as defined in paragraph (2) of subdivision (f) of Section 443.15.

(4) If a health care provider is unable or unwilling to carry out a qualified individual's request under this part and the qualified individual transfers care to a new health care provider or health care entity, the individual's relevant medical records shall be provided to the individual and, upon the individual's request, timely transferred with documentation of the date of the individual's request for a prescription for aid-in-dying drug in the medical record, pursuant to law.

(5) A health care provider or a health care entity shall not engage in false, misleading, or deceptive practices relating to a willingness to qualify an individual or provide a prescription to a qualified individual under this part.
(Amended by Stats. 2021, Ch. 542, Sec. 6. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.15. (Prohibition) (a) Subject to subdivision (b), notwithstanding any other law, a health care entity may prohibit its employees,

independent contractors, or other persons or entities, including health care providers, from participating under this part while on premises owned or under the management or direct control of that health care entity or while acting within the course and scope of any employment by, or contract with, the entity.

(b) A health care entity shall first give notice upon employment or other affiliation and thereafter annual notice of the policy concerning this part to the individual or entity. An entity that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity. For purposes of this subdivision, posting on the entity's public internet website the entity's current policy governing medical aid in dying shall satisfy the annual notice requirement.

(c) Subject to compliance with subdivision (b), the health care entity may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:

(1) Loss of privileges, loss of membership, or other action authorized by the bylaws or rules and regulations of the medical staff.

(2) Suspension, loss of employment, or other action authorized by the policies and practices of the health care entity.

(3) Termination of any lease or other contract between the health care entity and the individual or entity that violates the policy.

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the health care entity and the individual or entity in violation of the policy.

(d) This section does not prevent, or allow a health care entity to prohibit, any health care provider, employee, independent contractor, or other person or entity from any of the following:

(1) Participating, or entering into an agreement to participate, under this part, while on premises that are not owned or under the management or direct control of the health care entity or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the health care entity.

(2) Participating, or entering into an agreement to participate, under this part as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the health care entity.

(e) In taking actions pursuant to subdivision (c), a health care entity shall comply with all procedures required by law, its own policies or procedures, and any contract with the individual or entity in violation of the policy, as applicable.

(f) For purposes of this part:

(1) "Notice" means a separate statement in writing advising of the health care entity policy with respect to participating under this part.

(2) "Participating, or entering into an agreement to participate, under this part" means doing or entering into an agreement to do any one or more of the following:

(A) Performing the duties of an attending physician as specified in Section 443.5.

(B) Performing the duties of a consulting physician as specified in Section 443.6.

(C) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.

(D) Delivering the prescription for, dispensing, or delivering the dispensed aid-in-dying drug pursuant to paragraph (2) of subdivision (b) of, and subdivision (c) of, Section 443.5.

(E) Being present when the qualified individual takes the aid-in-dying drug prescribed pursuant to this part.

(3) “Participating, or entering into an agreement to participate, under this part” does not include doing, or entering into an agreement to do, any of the following:

(A) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.

(B) Providing information to a patient about this part.

(C) Providing a patient, upon the patient’s request, with a referral to another health care provider for the purposes of participating under this part.

(g) Any action taken by a health care entity pursuant to this section shall not be reportable under Sections 800 to 809.9, inclusive, of the Business and Professions Code. The fact that a health care provider participates under this part shall not be the sole basis for a complaint or report of unprofessional or dishonorable conduct under Sections 800 to 809.9, inclusive, of the Business and Professions Code.

(h) This part does not prevent a health care provider from providing an individual with health care services that do not constitute participation in this part.

(i) Each health care entity shall post on the entity’s public internet website the entity’s current policy governing medical aid in dying.

(j) A health care entity shall not engage in false, misleading, or deceptive practices relating to its policy concerning end-of-life care services nor engage in coercion or undue influence under this part.

(Amended by Stats. 2021, Ch. 542, Sec. 7. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.16. (Immunities)

(a) A health care provider may not be sanctioned for any of the following:

(1) Making an initial determination pursuant to the standard of care that an individual has a terminal disease and informing him or her of the medical prognosis.

(2) Providing information about the End of Life Option Act to a patient upon the request of the individual.

(3) Providing an individual, upon request, with a referral to another physician.

(b) A health care provider that prohibits activities under this part in accordance with Section 443.15 shall not sanction an individual health care provider for contracting with a qualified individual to engage in activities authorized by this part if the individual health care provider is acting outside of the course and scope of his or her capacity as an employee or independent contractor of the prohibiting health care provider.

(c) Notwithstanding any contrary provision in this section, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this part. Notwithstanding any contrary provision in this part, health care providers may be sanctioned by their licensing board or agency for conduct and actions constituting unprofessional conduct, including failure to comply in good faith with this part.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.17. (Penalties)	(a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without their authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual's death. (b) Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending their life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent, is punishable as a felony. (c) For purposes of this section, "knowingly" has the meaning provided in Section 7 of the Penal Code. (d) The attending physician, consulting physician, or mental health specialist shall not be related to the individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death. (e) This section does not limit civil liability or damages arising from negligent conduct or intentional misconduct in carrying out actions otherwise authorized by this part by any person, health care provider, or health care entity. (f) The penalties in this section do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of this part. (Amended by Stats. 2021, Ch. 542, Sec. 8. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.18. (Actions Taken)	Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law. (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)
443.19. (Data Collection)	(a) The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding. (b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician followup form and post that report to its Internet Web site. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department's access to vital statistics: (1) The number of people for whom an aid-in-dying prescription was written. (2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals. (3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of

aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.

(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.

(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.

(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:

(A) Age at death.

(B) Education level.

(C) Race.

(D) Sex.

(E) Type of insurance, including whether or not they had insurance.

(F) Underlying illness.

(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, as described in Section 443.22, by posting them on its Internet Web site.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.20. (Medication)

A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.21. (Costs Incurred)

Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

(Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215.)

443.215. (Repeal)

This part shall remain in effect only until January 1, 2031, and as of that date is repealed.

(Repealed and added by Stats. 2021, Ch. 542, Sec. 10. (SB 380) Effective January 1, 2022. Repealed as of January 1, 2031, by its own provisions. Note: Repeal affects Part 1.85, comprising Sections 443 to 443.22.)

443.22 (Medical Board Updates)	(a) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site. (b) Unless and until updated by the Medical Board of California pursuant to this section, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form shall be in the following form: ****************** NOTICE OF INCOMPLETE TEXT: The physician compliance and follow-up forms appear in the published chaptered bill. See Sec. 1 of Chapter 1 (pp. 18–25), 2nd Ex. Session, Statutes of 2015. ****************** (Added by Stats. 2015, 2nd Ex. Sess., Ch. 1, Sec. 1. (AB 15 2x) Effective June 9, 2016. Repealed as of January 1, 2031, pursuant to Section 443.215. Note: See published bill for complete section text. The physician compliance forms appear on pages 18 to 25 of Ch. 1 (2nd Ex.).)

Colorado

Short Title. The short title of this article is the “Colorado End-of-Life Options Act”.

Definitions. As used in this article 48, unless the context otherwise requires:

(1) “Adult” means an individual who is eighteen years of age or older.

(2) “Attending physician” means a physician who has primary responsibility for the care of a terminally ill individual and the treatment of the individual’s terminal illness.

(3) “Consulting physician” means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a terminally ill individual’s illness.

(4) “Health-care provider” or “provider” means a person who is licensed, certified, registered, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession. The term includes a health-care facility, including a long-term care facility as defined in section 25-3-103.7 (1)(f.3) and a continuing care retirement community as described in section 25.5-6-203 (1)(c)(I)(A).

(5) “Informed decision” means a decision that is:

(a) Made by an individual to obtain a prescription for medical aid-in-dying medication that the qualified individual may decide to self-administer to end his or her life in a peaceful manner;

(b) Based on an understanding and acknowledgment of the relevant facts; and

(c) Made after the attending physician fully informs the individual of:

(I) His or her medical diagnosis and prognosis of six months or less;

(II) The potential risks associated with taking the medical aid-in dying medication to be prescribed;

(III) The probable result of taking the medical aid-in-dying medication to be prescribed;

(IV) The choices available to an individual that demonstrate his or her self-determination and intent to end his or her life in a peaceful manner, including the ability to choose whether to:

(A) Request medical aid in dying;

(B) Obtain a prescription for medical aid-in-dying medication to end his or her life;

(C) Fill the prescription and possess medical aid-in-dying medication to end his or her life; and

(D) Ultimately self-administer the medical aid-in-dying medication to bring about a peaceful death; and

(V) All feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control.

(6) “Licensed mental health professional” means a psychiatrist licensed under article 240 of title 12 or a psychologist licensed under part 3 of article 245 of title 12.

(7) “Medical aid in dying” means the medical practice of a physician prescribing medical aid-in-dying medication to a qualified individual that the individual may choose to self-administer to bring about a peaceful death.

(8) “Medical aid-in-dying medication” means medication prescribed by a physician pursuant to this article to provide medical aid in dying to a qualified individual.

(9) “Medically confirmed” means that a consulting physician who has examined the terminally ill individual and the individual’s relevant medical records has confirmed the medical opinion of the attending physician.

(10) “Mental capacity” or “mentally capable” means that in the opinion of an individual’s attending physician, consulting physician, psychiatrist or psychologist, the individual has the ability to make and communicate an informed decision to health-care providers.

(11) “Physician” means a doctor of medicine or osteopathy licensed to practice medicine by the Colorado medical board.

(12) “Prognosis of six months or less” means a prognosis resulting from a terminal illness that the illness will, within reasonable medical judgment, result in death within six months and which has been medically confirmed.

(13) “Qualified individual” means a terminally ill adult with a prognosis of six months or less, who has mental capacity, has made an informed decision, is a resident of the state, and has satisfied the requirements of this article in order to obtain a prescription for medical aid-in-dying medication to end his or her life in a peaceful manner.

(14) “Resident” means an individual who is able to demonstrate residency in Colorado by providing any of the following documentation to his or her attending physician:

(a) A Colorado driver’s license or identification card issued pursuant to article 2 of title 42, C.R.S.;

(b) A Colorado voter registration card or other documentation showing the individual is registered to vote in Colorado;

(c) Evidence that the individual owns or leases property in Colorado; or

(d) A Colorado income tax return for the most recent tax year.

(15) “Self-administer” means a qualified individual’s affirmative, conscious, and physical act of administering the medical aid-in-dying medication to himself or herself to bring about his or her own death.

(16) “Terminal illness” means an incurable and irreversible illness that will, within reasonable medical judgment, result in death.

History

Source: Initiated 2016: Entire article added, Proposition 106, L. 2017, p. 2802, § 1, effective upon proclamation of the Governor, December 16, 2016.L. 2019:IP and (6) amended, (HB 19-1172), ch. 136, p. 1706, § 174, effective October 1.L. 2023:(4) amended, (HB 23-1228), ch. 278, p. 1650, § 5, effective May 30.

Right to Request Medical Aid-in-Dying Medication

(1) An adult resident of Colorado may make a request, in accordance with sections 25-48-104 and 25-48-112, to receive a prescription for medical aid-in-dying medication if:

(a) The individual’s attending physician has diagnosed the individual with a terminal illness with a prognosis of six months or less;

(b) The individual’s attending physician has determined the individual has mental capacity; and

(c) The individual has voluntarily expressed the wish to receive a prescription for medical aid-in-dying medication.

(2) The right to request medical aid-in-dying medication does not exist because of age or disability.

History

Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2804, § 1, effective upon proclamation of the Governor, December 16, 2016.

Request Process – Witness Requirements.	(1) In order to receive a prescription for medical aid-in-dying medication pursuant to this article, an individual who satisfies the requirements in section 25-48-103 must make two oral requests, separated by at least fifteen days, and a valid written request to his or her attending physician. (2) (a) To be valid, a written request for medical aid-in-dying medication must be: (I) Substantially in the same form as set forth in section 25-48-112; (II) Signed and dated by the individual seeking the medical aid-in-dying medication; and (III) Witnessed by at least two individuals who, in the presence of the individual, attest to the best of their knowledge and belief that the individual is: (A) Mentally capable; (B) Acting voluntarily; and (C) Not being coerced to sign the request. (b) Of the two witnesses to the written request, at least one must not be: (I) Related to the individual by blood, marriage, civil union, or adoption; (II) An individual who, at the time the request is signed, is entitled, under a will or by operation of law, to any portion of the individual's estate upon his or her death; or (III) An owner, operator, or employee of a health care facility where the individual is receiving medical treatment or is a resident. (c) Neither the individual's attending physician nor a person authorized as the individual's qualified power of attorney or durable medical power of attorney shall serve as a witness to the written request. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2805, § 1, effective upon proclamation of the Governor, December 16, 2016.
Right to Rescind Request – Requirement to Offer Opportunity to Rescind.	(1) At any time, an individual may rescind his or her request for medical aid-in-dying medication without regard to the individual's mental state. (2) An attending physician shall not write a prescription for medical aid-in-dying medication under this article unless the attending physician offers the qualified individual an opportunity to rescind the request for the medical aid-in-dying medication. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2805, § 1, effective upon proclamation of the Governor, December 16, 2016.
Attending Physician Responsibilities.	(1) The attending physician shall: (a) Make the initial determination of whether an individual requesting medical aid-in- dying medication has a terminal illness, has a prognosis of six months or less, is mentally capable, is making an informed decision, and has made the

request voluntarily;

(b) Request that the individual demonstrate Colorado residency by providing documentation as described in section 25-48-102 (14);

(c) Provide care that conforms to established medical standards and accepted medical guidelines;

(d) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis and for a determination of whether the individual is mentally capable, is making an informed decision, and acting voluntarily;

(e) Provide full, individual-centered disclosures to ensure that the individual is making an informed decision by discussing with the individual:

(I) His or her medical diagnosis and prognosis of six months or less;

(II) The feasible alternatives or additional treatment opportunities, including comfort care, palliative care, hospice care, and pain control;

(III) The potential risks associated with taking the medical aid-in-dying medication to be prescribed;

(IV) The probable result of taking the medical aid-in-dying medication to be prescribed; and

(V) The possibility that the individual can obtain the medical aid-in-dying medication but choose not to use it;

(f) Refer the individual to a licensed mental health professional pursuant to section 25-48-108 if the attending physician believes that the individual may not be mentally capable of making an informed decision;

(g) Confirm that the individual's request does not arise from coercion or undue influence by another person by discussing with the individual, outside the presence of other persons, whether the individual is feeling coerced or unduly influenced by another person;

(h) Counsel the individual about the importance of:

(I) Having another person present when the individual self-administers the medical aid-in-dying medication prescribed pursuant to this article;

(II) Not taking the medical aid-in-dying medication in a public place;

(III) Safe-keeping and proper disposal of unused medical aid-in-dying medication in accordance with section 25-48-120; and

(IV) Notifying his or her next of kin of the request for medical aid-in-dying medication;

(i) Inform the individual that he or she may rescind the request for medical aid-in-dying medication at any time and in any manner;

(j) Verify, immediately prior to writing the prescription for medical aid-in-dying medication, that the individual is making an informed decision;

(k) Ensure that all appropriate steps are carried out in accordance with this article before writing a prescription for medical aid-in-dying medication; and

(l) Either:

(I) Dispense medical aid-in-dying medications directly to the qualified individual, including ancillary medications intended to minimize the individual's discomfort, if the attending physician has a current drug enforcement administration certificate and complies with any applicable administrative rule; or

(II) Deliver the written prescription personally, by mail, or through authorized electronic transmission in the

manner permitted under article 280 of title 12, to a licensed pharmacist, who shall dispense the medical aid-in-dying medication to the qualified individual, the attending physician, or an individual expressly designated by the qualified individual.

History

Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2806, § 1, effective upon proclamation of the Governor, December 16, 2016.L. 2019:(1)(I)(II) amended, (HB 19-1172), ch. 136, p. 1706, § 175, effective October 1.

Consulting Physician Responsibilities.

Before an individual who is requesting medical aid-in-dying medication may receive a prescription for the medical aid-in-dying medication, a consulting physician must:

(1) Examine the individual and his or her relevant medical records;

(2) Confirm, in writing, to the attending physician:

(a) That the individual has a terminal illness;

(b) The individual has a prognosis of six months or less;

(c) That the individual is making an informed decision; and

(d) That the individual is mentally capable, or provide documentation that the consulting physician has referred the individual for further evaluation in accordance with section 25-48-108.

History

Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2807, § 1, effective upon proclamation of the Governor, December 16, 2016.

Confirmation that Individual is Mentally Capable – Referral to Mental Health Professional.

(1) An attending physician shall not prescribe medical aid-in-dying medication under this article for an individual with a terminal illness until the individual is determined to be mentally capable and making an informed decision, and those determinations are confirmed in accordance with this section.

(2) If the attending physician or the consulting physician believes that the individual may not be mentally capable of making an informed decision, the attending physician or consulting physician shall refer the individual to a licensed mental health professional for a determination of whether the individual is mentally capable and making an informed decision.

(3) A licensed mental health professional who evaluates an individual under this section shall communicate, in writing, to the attending or consulting physician who requested the evaluation, his or her conclusions about whether the individual is mentally capable and making informed decisions. If the licensed mental health professional determines that the individual is not mentally capable of making informed decisions, the person shall not be deemed a qualified individual under this article and the attending physician shall not prescribe medical aid-in-dying medication to the individual.

History

Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2808, § 1, effective upon proclamation of the Governor, December 16, 2016.

Colorado

Death Certificate.	(1) Unless otherwise prohibited by law, the attending physician or the hospice medical director shall sign the death certificate of a qualified individual who obtained and self-administered aid-in-dying medication. (2) When a death has occurred in accordance with this article, the cause of death shall be listed as the underlying terminal illness and the death does not constitute grounds for post-mortem inquiry under section 30-10-606(1), C.R.S. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2808, § 1, effective upon proclamation of the Governor, December 16, 2016.
Informed Decision Required.	(1) An individual with a terminal illness is not a qualified individual and may not receive a prescription for medical aid-in-dying medication unless he or she has made an informed decision. (2) Immediately before writing a prescription for medical aid-in-dying medication under this article, the attending physician shall verify that the individual with a terminal illness is making an informed decision. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2808, § 1, effective upon proclamation of the Governor, December 16, 2016.
Medical Record Documentation Requirements – Reporting Requirements – Department Compliance Reviews – Rules.	(1) The attending physician shall document in the individual's medical record, the following information: (a) Dates of all oral requests; (b) A valid written request; (c) The attending physician's diagnosis and prognosis, determination of mental capacity and that the individual is making a voluntary request and an informed decision; (d) The consulting physician's confirmation of diagnosis and prognosis, mental capacity and that the individual is making an informed decision; (e) If applicable, written confirmation of mental capacity from a licensed mental health professional; (f) A notation of notification of the right to rescind a request made pursuant to this article; and (g) A notation by the attending physician that all requirements under this article have been satisfied; indicating steps taken to carry out the request, including a notation of the medical aid-in-dying medications prescribed and when. (2) (a) The department of public health and environment shall annually review a sample of records maintained pursuant to this article to ensure compliance. The department shall adopt rules to facilitate the collection of information defined in subsection (1) of this section. Except as otherwise required by law, the information collected by the department is not a public record and is not available for public inspection. However, the department shall generate and make available to the public an annual statistical report of information collected under this subsection (2). (b) The department shall require any health-care provider, upon dispensing a medical aid-in-dying medication pursuant to this article, to file a copy of a dispensing record with the department. The dispensing record is not a public record and is not available for public inspection. History

	Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2809, § 1, effective upon proclamation of the Governor, December 16, 2016.
Form of Written Request.	*** Refer directly to statute for form of patient written request. ***
Standard of Care.	(1) Physicians and health care providers shall provide medical services under this act that meet or exceed the standard of care for end-of-life medical care. (2) If a health care provider is unable or unwilling to carry out an eligible individual' s request and the individual transfers care to a new health care provider, the health care provider shall coordinate transfer of the individual's medical records to a new health care provider. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2811, § 1, effective upon proclamation of the Governor, December 16, 2016.
Effect on Wills, Contracts, and Statutes.	(1) A provision in a contract, will, or other agreement, whether written or oral, that would affect whether an individual may make or rescind a request for medical aid in dying pursuant to this article is invalid. (2) An obligation owing under any currently existing contract must not be conditioned upon, or affected by, an individual's act of making or rescinding a request for medical aid-in-dying medication pursuant to this article. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2811, § 1, effective upon proclamation of the Governor, December 16, 2016.
Insurance or Annuity Policies.	(1) The sale, procurement, or issuance of, or the rate charged for, any life, health, or accident insurance or annuity policy must not be conditioned upon, or affected by, an individual's act of making or rescinding a request for medical aid-in-dying medication in accordance with this article. (2) A qualified individual's act of self-administering medical aid-in-dying medication pursuant to this article does not affect a life, health, or accident insurance or annuity policy. (3) An insurer shall not deny or otherwise alter health care benefits available under a policy of sickness and accident insurance to an individual with a terminal illness who is covered under the policy, based on whether or not the individual makes a request pursuant to this article. (4) An individual with a terminal illness who is a recipient of medical assistance under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of title 25.5, C.R.S. shall not be denied benefits under the medical assistance program or have his or her benefits under the program otherwise altered based on whether or not the individual makes a request pursuant to this article.

	History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2811, § 1, effective upon proclamation of the Governor, December 16, 2016.
Immunity for Actions in Good Faith – Prohibition Against Reprisals.	(1) A person is not subject to civil or criminal liability or professional disciplinary action for acting in good faith under this article, which includes being present when a qualified individual self-administers the prescribed medical aid-in-dying medication. (2) Except as provided for in section 25-48-118, a health care provider or professional organization or association shall not subject an individual to any of the following for participating or refusing to participate in good-faith compliance under this article: (a) Censure; (b) Discipline; (c) Suspension; (d) Loss of license, privileges, or membership; or (e) Any other penalty. (3) A request by an individual for, or the provision by an attending physician of, medical aid-in-dying medication in good-faith compliance with this article does not: (a) Constitute neglect or elder abuse for any purpose of law; or (b) Provide the basis for the appointment of a guardian or conservator. (4) This section does not limit civil or criminal liability for negligence, recklessness, or intentional misconduct. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2812, § 1, effective upon proclamation of the Governor, December 16, 2016.
No Duty to Prescribe or Dispense.	(1) A health care provider may choose whether to participate in providing medical aid-in-dying medication to an individual in accordance with this article. (2) If a health care provider is unable or unwilling to carry out an individual's request for medical aid-in-dying medication made en accordance with this article, and the individual transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the individual's relevant medical records to the new health care provider. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2812, § 1, effective upon proclamation of the Governor, December 16, 2016.
Health Care Facility Permissible	(1) A health care facility may prohibit a physician employed or under contract from writing a prescription for medical aid-in-dying medication for a qualified individual who intends to use the medical aid-in-dying medication on the facility's

Prohibitions – Sanctions if Provider Violates Policy.	premises. The health care facility must notify the physician in writing of its policy with regard to prescriptions for medical aid-in-dying medication. A health care facility that fails to provide advance notice to the physician shall not be entitled to enforce such a policy against the physician. (2) A health care facility or health care provider shall not subject a physician, nurse, pharmacist, or other person to discipline, suspension, loss of license or privileges, or any other penalty or sanction for actions taken in good-faith reliance on this article or for refusing to act under this article. (3) A health care facility must notify patients in writing of its policy with regard to medical aid-in-dying. A health care facility that fails to provide advance notification to patients shall not be entitled to enforce such a policy. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2812, § 1, effective upon proclamation of the Governor, December 16, 2016.
Liabilities.	(1) A person commits a class 2 felony and is subject to punishment in accordance with section 18-1.3-401, C.R.S. If the person, knowingly or intentionally causes an individual's death by: (a) Forging or altering a request for medical aid-in-dying medication to end an individual's life without the individual's authorization; or (b) Concealing or destroying a rescission of a request for medical aid-in-dying medication. (2) A person commits a class 2 felony and is subject to punishment in accordance with section 18-1.3-401, C.R.S. if the person knowingly or intentionally coerces or exerts undue influence on an individual with a terminal illness to: (a) Request medical aid-in-dying medication for the purpose of ending the terminally ill individual's life; or (b) Destroy a rescission of a request for medical aid-in-dying medication. (3) Nothing in this article limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person. (4) The penalties specified in this article do not preclude criminal penalties applicable under the "Colorado Criminal Code", title 18, C.R.S., for conduct that is inconsistent with this article. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2813, § 1, effective upon proclamation of the Governor, December 16, 2016.
Safe Disposal of Unused Medical Aid-in-Dying Medications.	A person who has custody or control of medical aid-in-dying medication dispensed under this article that the terminally ill individual decides not to use or that remains unused after the terminally ill individual's death shall dispose of the unused medical aid-in-dying medication either by: (1) Returning the unused medical aid-in-dying medication to the attending physician who prescribed the medical aid-in-dying medication, who shall dispose of the unused medical aid-in-dying medication in the manner required by law; or (2) Lawful means in accordance with section 25-15-328, C.R.S. or any other state or federally approved medication take-back program authorized under the federal "Secure and Responsible Drug Disposal act of 2010", pub.L. 111-273, and

	regulations adopted pursuant to the federal act. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2813, § 1, effective upon proclamation of the Governor, December 16, 2016.
Actions Complying With Article Not a Crime.	Nothing in this article authorizes a physician or any other person to end an individual's life by lethal injection, mercy killing, or euthanasia. Actions taken in accordance with this article do not, for any purpose, constitute suicide, assisted suicide, mercy killing, homicide, or elder abuse under the "Colorado Criminal Code", as set forth in title 18, C.R.S. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2814, § 1, effective upon proclamation of the Governor, December 16, 2016.
Claims by Government Entity for Costs.	A government entity that incurs costs resulting from an individual terminating his or her life pursuant to this article in a public place has a claim against the estate of the individual to recover the costs and reasonable attorney fees related to enforcing the claim. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2814, § 1, effective upon proclamation of the Governor, December 16, 2016.
No Effect on Advance Medical Directives.	Nothing in this article shall change the legal effect of: (1) A declaration made under article 18 of title 15, C.R.S., directing that life sustaining procedures be withheld or withdrawn; (2) A cardiopulmonary resuscitation directive executed under article 18.6 of title 15, C.R.S.; or (3) An advance medical directive executed under article 18.7 of title 15, C.R.S. History Source:Initiated 2016:Entire article added, Proposition 106, L. 2017, p. 2814, § 1, effective upon proclamation of the Governor, December 16, 2016.

Definitions.

"Adult" means an individual who is eighteen years of age or older.
"Advanced practice registered nurse" means a registered nurse licensed to practice in the State who has met the qualifications of chapter 457 and who, because of advanced education and specialized clinical training, is authorized to assess, screen, diagnose, order, utilize, or perform medical, therapeutic, preventive, or corrective measures, including prescribing medication.
"Attending provider" means a physician licensed pursuant to chapter 453 or advanced practice registered nurse licensed pursuant to chapter 457 who has responsibility for the care of the patient and treatment of the patient's terminal disease.
"Capable" means that in the opinion of the patient's attending provider or consulting provider, psychiatrist, psychologist, or clinical social worker, a patient has the ability to understand the patient's choices for care, including risks and benefits, and make and communicate health care decisions to health care providers.
"Consulting provider" means a physician licensed pursuant to chapter 453 who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease or advanced practice registered nurse licensed pursuant to chapter 457 who is qualified by specialty or experience to diagnose and prescribe medication.
"Counseling" means one or more consultations, which may be provided through telehealth, as necessary between a psychiatrist licensed under chapter 453, psychologist licensed under chapter 465, clinical social worker licensed pursuant to chapter 467E, advanced practice registered nurse or clinical nurse specialist licensed under chapter 457 with psychiatric or mental health training, or marriage and family therapist licensed pursuant to chapter 451J, and a patient for the purpose of determining that the patient is capable, and that the patient does not appear to be suffering from undertreatment or nontreatment of depression or other conditions that may interfere with the patient's ability to make an informed decision pursuant to this chapter.
"Department" means the department of health.
"Health care facility" shall have the same meaning as in section 323D-2.
"Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care or dispense medication in the ordinary course of business or practice of a profession.
"Informed decision" means a decision by a qualified patient to request and obtain a prescription to end the qualified patient's life pursuant to this chapter. The informed decision shall be based on an appreciation of the relevant facts and made after being fully informed by the attending provider of:

(1) The medical diagnosis;
(2) The prognosis;
(3) The potential risks associated with taking the medication to be prescribed;
(4) The probable result of taking the medication to be prescribed;
(5) The possibility that the individual may choose not to obtain the medication or may obtain the medication and may decide not to use it; and
(6) The feasible alternatives or additional treatment opportunities, including but not limited to comfort care, hospice care, and pain control.

"Medically confirmed" means the medical opinion of the attending provider has been confirmed by a consulting provider

who has examined the patient and the patient's relevant medical records.
"Patient" means a person who is under the care of an attending provider.
"Physician" means a doctor of medicine or osteopathy licensed to practice medicine pursuant to chapter 453 by the Hawaii medical board.
"Prescription" means prescription medication or medications that the qualified patient may self-administer to end the qualified patient's life pursuant to this chapter.
"Qualified patient" means a capable adult who is a resident of the State and has satisfied the requirements of this chapter in order to obtain a prescription to end the qualified patient's life pursuant to this chapter.
"Self-administer" means an individual performing an affirmative, conscious, voluntary act to take into the individual's body prescription medication to end the individual's life pursuant to this chapter.
"Telehealth" shall have the same meaning as defined in section 453-1.3.
"Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.
"Terminal disease" does not include age or any physical disability or condition that is not likely to, by itself, cause death within six months. [L 2018, c 2, pt of §3; am L 2023, c 43, §2]

Oral and Written Requests for Medication; Initiated.

Except as otherwise provided in section 327L-11(c), an adult who is capable, is a resident of the State, and has been determined by an attending provider and a consulting provider to be suffering from a terminal disease, and who has voluntarily expressed the adult's wish to die, may, pursuant to section 327L-9, submit:

(1) Two oral requests, a minimum of five days apart; and

(2) One written request,

for a prescription for medication that may be self-administered for the purpose of ending the adult's life in accordance with this chapter. The attending provider shall directly, and not through a designee, receive all three requests required pursuant to this section. [L 2018, c 2, pt of §3; am L 2023, c 43, §3]

Form of the Written Request.

(a) A valid written request for a prescription under this chapter shall be substantially in the form described in section 327L-23, and shall be signed and dated by the qualified patient and witnessed by at least two individuals who, in the presence of the qualified patient, attest that to the best of their knowledge and belief the qualified patient is of sound mind, acting voluntarily, and is not being coerced to sign the request.

(b) One of the witnesses shall be a person who is not:

(1) A relative of the qualified patient by blood, marriage, or adoption;

(2) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will, trust, or other legal instrument, or by operation of law; or

(3) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(c) The qualified patient's attending provider at the time the request is signed shall not be a witness. [L 2018, c 2, pt of

§3]

Attending Provider; Duties.

(a) The attending provider shall:

(1) Make the initial determination of whether a patient has a terminal disease, is capable of medical decision-making, and has made the request for the prescription voluntarily;

(2) Require that the patient demonstrate residency pursuant to section 327L-13;

(3) To ensure that the patient is making an informed decision, inform the patient of the:

(A) Patient's medical diagnosis;

(B) Patient's prognosis;

(C) Potential risks associated with taking the medication to be prescribed;

(D) Probable result of taking the medication to be prescribed;

(E) Possibility that the individual may choose not to obtain the medication or may obtain the medication but may decide not to use it; and

(F) Feasible alternatives or additional treatment opportunities, including but not limited to comfort care, hospice care, and pain control;

(4) Refer the patient to a consulting provider for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(5) Refer the patient for counseling;

(6) Recommend that the patient notify next of kin;

(7) Counsel the patient about the importance of having another person present when the qualified patient self-administers the prescription prescribed pursuant to this chapter and of not self-administering the prescription in a public place;

(8) Inform the patient that a qualified patient may rescind the request at any time and in any manner, and offer the qualified patient an opportunity to rescind the request at the time of the qualified patient's second oral request made pursuant to section 327L-9;

(9) Verify, immediately prior to writing the prescription for medication under this chapter, that the qualified patient is making an informed decision;

(10) Fulfill the medical record documentation requirements of section 327L-12;

(11) Ensure that all appropriate steps are carried out in accordance with this chapter prior to writing a prescription for medication to enable a qualified patient to end the qualified patient's life pursuant to this chapter; and

(12) Either:

(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort; provided that the attending provider is authorized to dispense controlled substances pursuant to chapter 329, has a current Drug Enforcement Administration certificate, and complies with any applicable administrative rules; or

(B) With the qualified patient's written consent:

(i) Contact a pharmacist of the qualified patient's choice and inform the pharmacist of the prescription; and

(ii) Transmit the written prescription personally, by mail, or electronically to the pharmacist, who shall dispense the medication to either the qualified patient, the attending provider, or an expressly identified agent of the qualified patient.

(b) Notwithstanding any other provision of law, an attending provider may sign the qualified patient's death certificate. The death certificate shall list the terminal disease as the immediate cause of death. [L 2018, c 2, pt of §3]

Consulting Provider; Confirmation.

Before a patient is qualified under this chapter, a consulting provider shall examine the patient and the patient's relevant medical records and confirm, in writing, the attending provider's diagnosis that the patient is suffering from a terminal disease and the attending provider's prognosis, and verify that the patient is capable, is acting voluntarily, and has made an informed decision. [L 2018, c 2, pt of §3]

Counseling Referral.

The attending provider shall refer the patient for counseling. No medication to end a patient's life pursuant to this chapter shall be prescribed until the person performing the counseling determines that the patient is capable, and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter. [L 2018, c 2, pt of §3]

Informed Decision.

No qualified patient shall receive a prescription for medication to end the qualified patient's life pursuant to this chapter unless the qualified patient has made an informed decision. Immediately prior to writing a prescription under this chapter, the attending provider shall verify that the qualified patient is making an informed decision. [L 2018, c 2, pt of §3]

Family Notification.

The attending provider shall recommend that the qualified patient notify the qualified patient's next of kin of the request for a prescription pursuant to this chapter. A qualified patient who declines or is unable to notify next of kin shall not have the qualified patient's request denied solely for that reason. [L 2018, c 2, pt of §3]

Written and Oral Requests.

Except as otherwise provided in section 327L-11(c), to receive a prescription for medication that a qualified patient may self-administer to end the qualified patient's life pursuant to this chapter, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to the qualified patient's attending provider no less than five days after making the initial oral request. At the time the qualified patient makes the second oral request, the attending provider shall offer the qualified patient an opportunity to rescind the request. [L 2018, c 2, pt of §3; am L 2023, c 43, §4]

Right to Rescind Request.

A qualified patient may rescind the request at any time and in any manner without regard to the qualified patient's mental state. No prescription under this chapter shall be made available pursuant to section 327L-4(a)(12) if the

attending provider has not offered the qualified patient an opportunity to rescind the request at the time of the second oral request made pursuant to section 327L-9. [L 2018, c 2, pt of §3]

Waiting Periods.

(a) Except as otherwise provided in subsection (c), no less than five days shall elapse between the qualified patient's initial oral request for a prescription for medication pursuant to sections 327L-2 and 327L-9, and the taking of steps to make available a prescription pursuant to section 327L-4(a)(12).
(b) No less than forty-eight hours shall elapse between the qualified patient's written request for a prescription for medication pursuant to sections 327L-2 and 327L-9, and the taking of steps to make available a prescription pursuant to section 327L-4(a)(12).
(c) If the qualified patient's attending provider attests that the qualified patient will, within a reasonable medical judgment, die within five days after making the initial oral request, the five-day waiting period shall be waived and the qualified patient may reiterate the oral request to the attending provider at any time after making the initial oral request. [L 2018, c 2, pt of §3; am L 2023, c 43, §5]

Medical Record; Documentation Requirements.

The following shall be documented or filed in a qualified patient's medical record:
(1) All oral requests by the qualified patient for a prescription to end the qualified patient's life pursuant to this chapter;
(2) All written requests by the qualified patient for a prescription to end the qualified patient's life pursuant to this chapter;
(3) The attending provider's diagnosis and prognosis and determination that the qualified patient is capable, acting voluntarily, and has made an informed decision;
(4) The consulting provider's diagnosis and prognosis and verification that the qualified patient is capable, acting voluntarily, and has made an informed decision;
(5) The counselor's statement of determination that the patient is capable, and does not appear to be suffering from undertreatment or nontreatment of depression or other conditions which may interfere with the patient's ability to make an informed decision pursuant to this chapter;
(6) The attending provider's offer to the qualified patient to rescind the patient's request at the time of the qualified patient's second oral request made pursuant to section 327L-9; and
(7) A statement by the attending provider indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including identification of the medication prescribed. [L 2018, c 2, pt of §3]

Residency Requirement.

Only requests made by residents of this State shall be granted under this chapter. Factors demonstrating state residency include but are not limited to:
(1) Possession of a Hawaii driver's license or civil identification card;
(2) Registration to vote in Hawaii;
(3) Evidence that the patient owns or leases property in Hawaii; or
(4) Filing of a Hawaii tax return for the most recent tax year. [L 2018, c 2, pt of §3]

Reporting Requirements.	(a) Within thirty calendar days of writing a prescription, the attending provider shall submit a copy of the qualified patient's written request, as well as [a] copy of all the documentation required pursuant to section 327L-12 to the department. (b) Within thirty calendar days following notification of the qualified patient's death from use of a prescribed medication pursuant to this chapter, or any other cause, the attending provider shall submit any follow-up information to the documentation required pursuant to section 327L-12 to the department. (c) The department shall annually collect and review all information submitted pursuant to this chapter. The information collected shall be confidential and shall be collected in such a manner that protects the privacy of all qualified patients, the qualified patients' family, and any attending provider, consulting provider, or counselor involved with a qualified patient pursuant to this chapter. Information collected pursuant to this section by the department shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding. (d) On or before July 1, 2019, and each year thereafter, the department shall create a report of information collected under subsection (c) and vital statistics records maintained by the department and shall post the report on the department's website. Information contained in the report shall only include: (1) The number of qualified patients for whom a prescription was written pursuant to this chapter; (2) The number of known qualified patients who died each year for whom a prescription was written pursuant to this chapter and the cause of death of those qualified patients; (3) The total number of prescriptions written pursuant to this chapter for the year in which the report was created as well as cumulatively for all years beginning with 2019; (4) The total number of qualified patients who died while enrolled in hospice or other similar palliative care program; (5) The number of known deaths in Hawaii from a prescription written pursuant to this chapter per five-thousand deaths in Hawaii; (6) The number of attending providers who wrote prescriptions pursuant to this chapter; (7) Of the people who died as a result of self-administering a prescription pursuant to this chapter, the individual's: (A) Age at death; (B) Education level; (C) Race; (D) Sex; (E) Type of insurance, if any; and (F) Underlying illness; and (8) Any other data deemed appropriate by the department. [L 2018, c 2, pt of §3]
Disposal of Unused Medication.	A person who has custody or control of any unused medication dispensed under this chapter after the death of a qualified patient shall personally deliver the unused medication for disposal to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means. [L 2018, c 2, pt of §3]

Effect on Construction of Wills or Contracts.	(a) No provision in any will or contract, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for a prescription to end the person's life pursuant to this chapter, shall be valid. (b) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for a prescription to end the person's life pursuant to this chapter. [L 2018, c 2, pt of §3]
Insurance or Annuity Policies.	The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any such policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for a prescription to end the person's life pursuant to this chapter. A qualified patient's act of using medication to end the qualified patient's life pursuant to this chapter shall have no effect upon a life, health, or accident insurance or annuity policy. [L 2018, c 2, pt of §3]
Construction of Chapter.	(a) Nothing in this chapter shall be construed to authorize a health care provider, health care facility, or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, murder, manslaughter, negligent homicide, or any other criminal conduct under the law. (b) Nothing in this chapter shall be construed to allow a lower standard of care for qualified patients in the community where the qualified patient is treated or in a similar community. [L 2018, c 2, pt of §3]
Immunities; Basis for Prohibiting Health Care Provider From Participation; Notification; Permissible Sanctions.	(a) Except as provided in section 327L-20 and subsection (c): (1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating or acting in good faith compliance with this chapter, including being present when a qualified patient self-administers the prescribed medication to end the qualified patient's life pursuant to this chapter; (2) No professional organization or association, health care provider, or health care facility shall subject any person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter; (3) No request by a qualified patient for a prescription or provision by a health care provider of a prescription or medication in good faith compliance with this chapter shall constitute neglect, harm, self-neglect, or abuse for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; (4) No health care provider or health care facility shall be under any duty, whether by contract, statute, or any other legal requirement, to participate in the provision to a qualified patient of a prescription or of medication to end the qualified patient's life pursuant to this chapter. If a health care provider is unable or unwilling to carry out a patient's request under this chapter and the patient transfers the patient's care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care

provider; and

(5) No health care facility shall be subject to civil or criminal liability for acting in good faith compliance with this chapter.

(b) Notwithstanding any other provision of law, a health care facility may prohibit a health care provider from participating in actions covered by this chapter on the premises of the health care facility if the health care facility has notified the health care provider of the health care facility's policy regarding participation in actions covered by this chapter. Nothing in this subsection shall prevent a health care provider from providing health care services to a patient that do not constitute participation in actions covered by this chapter.

(c) Subsection (a) notwithstanding, if the health care facility has notified the health care provider prior to participation in actions covered by this chapter that the health care facility prohibits participation on its premises in actions covered by this chapter, the health care facility may subject the health care provider to the following sanctions:

(1) Loss of privileges, loss of membership, or other sanction provided pursuant to the medical staff bylaws, policies, and procedures of the health care facility if the health care provider is a member of the health care facility's medical staff and participates in actions covered by this chapter while on the premises of the health care facility other than in the private medical office of the health care provider;

(2) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the health care provider participates in actions covered by this chapter while on the premises of the health care facility or on property that is owned by or under the direct control of the health care facility; or

(3) Termination of contract or other nonmonetary remedies provided by contract if the health care provider participates in actions covered by this chapter while acting in the course and scope of the health care provider's capacity as an employee or independent contractor of the health care facility; provided that nothing in this paragraph shall be construed to prevent:

(A) A health care provider from participating in actions covered by this chapter while acting outside the course and scope of the health care provider's capacity as an employee or independent contractor; or

(B) A patient from contracting with the patient's attending provider, consulting provider, or counselor to act outside the course and scope of those providers' capacity as an employee or independent contractor of the health care facility.

(d) A health care facility that imposes sanctions pursuant to subsection (c) shall follow all due process and other procedures the health care facility may have that are related to the imposition of sanctions on a health care provider.

(e) For the purposes of this section:

"Notify" means to deliver a separate statement in writing to a health care provider specifically informing the health care provider before the health care provider's participation in actions covered by this chapter of the health care facility's policy regarding participation in actions covered by this chapter.

"Participation in actions covered by this chapter" means the performance of duties of an attending provider pursuant to section 327L-4, the consulting provider function pursuant to section 327L-5, or the counseling referral function or counseling pursuant to section 327L-6. "Participation in actions covered by this chapter" does not include:

(1) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;
(2) Providing information about this chapter to a patient upon the request of the patient;
(3) Providing a patient, upon the request of the patient, with a referral to another health care provider; or
(4) Entering into a contract with a patient as the patient's attending provider, consulting provider, or counselor to act outside of the course and scope of the health care provider's capacity as an employee or independent contractor of a health care facility.
(f) Action taken pursuant to sections 327L-4 through 327L-6 shall not be the sole basis for disciplinary action under sections 453-8, 465-13, or 467E-12. [L 2018, c 2, pt of §3; am L 2023, c 43, §6]

Prohibited Acts; Penalties.	(a) Any person who intentionally makes, completes, alters, or endorses a request for a prescription made pursuant to section 327L-2, for another person, or conceals or destroys any documentation of a rescission of a request for a prescription completed by another person, shall be guilty of a class A felony. (b) Any person who knowingly coerces or induces a patient by force, threat, fraud, or intimidation to request a prescription pursuant to section 327L-2, shall be guilty of a class A felony. (c) Nothing in this section shall limit any liability for civil damages resulting from any intentional or negligent conduct by any person in violation of this chapter. (d) The penalties in this chapter are cumulative and shall not preclude criminal penalties pursuant to other applicable state law. [L 2018, c 2, pt of §3]
Claims by Governmental Entity for Costs Incurred.	Any governmental entity that incurs costs resulting from a person terminating the person's life pursuant to this chapter in a public place shall have a claim against the estate of the person to recover costs and reasonable attorneys' fees related to enforcing the claim. [L 2018, c 2, pt of §3]
Severability.	Any provision of this chapter that is held invalid as to any person or circumstance shall not affect the application of any other provision of this chapter that can be given full effect without the invalid provision or application. [L 2018, c 2, pt of §3]
Form of the Request.	*** Refer directly to statute for form of patient written request. ***
Form of Final Attestation.	(a) A final attestation form shall be given to a qualified patient at the time an attending provider writes or dispenses the prescription authorized by this chapter and shall be in substantially the following form: *** Refer directly to statute for form of final attestation. *** (b) The final attestation form shall be completed by the qualified patient within forty-eight hours prior to the qualified [patient's] self-administration of the medication prescribed pursuant to this chapter. Upon the qualified patient's death,

the completed final attestation form shall be delivered by the qualified patient's health care provider, family member, or other representative to the attending provider for inclusion in the qualified patient's medical record. [L 2018, c 2, pt of §3]

Annual Report.

The department shall submit to the legislature an annual report no later than twenty days prior to the convening of each regular session. The report shall include but not be limited to:
(1) An annual analysis of the implementation of this chapter, including any implementation problems; and
(2) Any proposed legislation. [L 2018, c 2, pt of §3]

Maine

(Positive Defense)

Be it enacted by the People of the State of Maine as follows:
Sec. 1. 17-A MRSA §152-A, sub-§3 is enacted to read:
3. It is an affirmative defense to prosecution under subsection 1 that the person's conduct was expressly authorized by Title 22, chapter 418.
Sec. 2. 17-A MRSA §201, sub-§6 is enacted to read:
6. It is an affirmative defense to prosecution under subsection 1 that the person's conduct was expressly authorized by Title 22, chapter 418.
Sec. 3. 17-A MRSA §204, sub-§3 is enacted to read:
3. It is an affirmative defense to prosecution under subsection 1 that the person's conduct was expressly authorized by Title 22, chapter 418.

Short Title.

This chapter may be known and cited as "the Maine Death with Dignity Act."

Definitions.

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.
A. "Adult" means a person who is 18 years of age or older.
B. "Attending physician" means the physician who has primary responsibility for the care of a patient and the treatment of that patient's terminal disease.
C. "Competent" means that, in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
D. "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's disease.
E. "Counseling" means one or more consultations between a state-licensed psychiatrist, state-licensed psychologist, state-licensed clinical social worker or state-licensed clinical professional counselor and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
F. "Health care provider" means:
(1) A person licensed, certified or otherwise authorized or permitted by law to administer health care services or dispense medication in the ordinary course of business or practice of a profession; or
(2) A health care facility.
G. "Informed decision" means a decision by a qualified patient to request and obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner that is based on an appreciation of the relevant facts and that is made after being fully informed by the attending physician of:
(1) The qualified patient's medical diagnosis;

(2) The qualified patient's prognosis;
(3) The potential risks associated with taking the medication to be prescribed;
(4) The probable result of taking the medication to be prescribed; and
(5) The feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options.
H. "Medically confirmed" means the medical opinion of an attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
I. "Patient" means an adult who is under the care of a physician.
J. "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this State.
K. "Qualified patient" means a competent adult who is a resident of this State and who has satisfied the requirements of this Act in order to obtain a prescription for medication that the qualified patient may self-administer to end the qualified patient's life in a humane and dignified manner.
L. "Self-administer" means, for a qualified patient, to voluntarily ingest medication to end the qualified patient's life in a humane and dignified manner.
M. "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within 6 months.

Right to Information.	A patient has a right to information regarding all treatment options reasonably available for the care of the patient, including, but not limited to, information in response to specific questions about the foreseeable risks and benefits of medication, without a physician's withholding requested information regardless of the purpose of the questions or the nature of the information.
Written Request for Medication.	An adult who is competent, is a resident of this State, has been determined by an attending physician and a consulting physician to be suffering from a terminal disease and has voluntarily expressed the wish to die may make a written request for medication that the adult may self-administer in accordance with this Act. An adult does not qualify under this Act solely because of age or disability.
Form of Written Request.	A valid request for medication under this Act must be substantially in the form described in subsection 24, signed and dated by the patient and witnessed by at least 2 individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, is acting voluntarily and is not being coerced to sign the request. A. The language of a written request for medication under this Act must be the language in which any conversations or consultations or interpreted conversations or consultations between a patient and the patient's attending physician or consulting physician are held. B. Notwithstanding paragraph A, the language of a written request for medication under this Act may be English when the conversations or consultations or interpreted conversations or consultations between a patient and the patient's attending physician or consulting physician were conducted in a language other than English if the form described in

subsection 24 contains the attachment described in subsection 25.
C. At least one of the 2 or more witnesses required under this subsection and any interpreter required under this subsection must be a person who is not:
(1) A relative of the patient by blood, marriage or adoption;
(2) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death, under any will or by operation of any law; or
(3) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
D. The patient's attending physician at the time the written request is signed may not be a witness.
E. If the patient is a patient in a long-term care facility at the time the patient makes the written request, one of the witnesses must be an individual designated by the facility who has the qualifications specified by the department by rule.

Attending Physician Responsibilities.

The attending physician shall:
A. Make the initial determination of whether a patient has a terminal disease, is competent and has made the written request under subsection 4 voluntarily;
B. Request that the patient demonstrate state residency as required by subsection 15;
C. To ensure that the patient is making an informed decision, inform the patient of:
(1) The patient's medical diagnosis;
(2) The patient's prognosis;
(3) The potential risks associated with taking the medication to be prescribed;
(4) The probable result of taking the medication to be prescribed; and
(5) The feasible alternatives to taking the medication to be prescribed, including palliative care and comfort care, hospice care, pain control and disease-directed treatment options;
D. Refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is competent and acting voluntarily;
E. Confirm that the patient's request does not arise from coercion or undue influence by another individual by discussing with the patient, outside the presence of any other individual, except for an interpreter, whether the patient is feeling coerced or unduly influenced;
F. Refer the patient for counseling, if appropriate, as described in subsection 8;
G. Recommend that the patient notify the patient's next of kin;
H. Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this Act, and counsel the patient about not taking the medication prescribed under this Act in a public place;
I. Inform the patient that the patient has an opportunity to rescind the request at any time and in any manner and offer the patient an opportunity to rescind the request at the end of the 15-day waiting period pursuant to subsection 11;
J. Verify, immediately before writing the prescription for medication under this Act, that the patient is making an informed

	decision; K. Fulfill the medical record documentation requirements of subsection 14; L. Ensure that all appropriate steps are carried out in accordance with this Act before writing a prescription for medication to enable a qualified patient to end the qualified patient's life in a humane and dignified manner; and M. Dispense medications directly, including ancillary medications intended to minimize the patient's discomfort, if the attending physician is authorized under state law or rule to dispense medications and has a current drug enforcement administration certificate or with the patient's written consent: (1) Contact a pharmacist and inform the pharmacist of the prescription; and (2) Deliver the written prescription personally, by mail or electronically to the pharmacist, who may dispense the medications in person to the patient, the attending physician or an expressly identified agent of the patient.
Consulting Physician Confirmation.	Before a patient is determined to be a qualified patient under this Act, a consulting physician shall examine the patient and the patient's relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease and verify that the patient is competent, is acting voluntarily and has made an informed decision.
Consulting Referral.	If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, the physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner may not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
Informed Decision.	A qualified patient may not receive a prescription for medication under this Act unless the qualified patient has made an informed decision. Immediately before writing a prescription for medication under this Act, the attending physician shall verify that the qualified patient is making an informed decision.
Notification of Next of Kin.	A patient who declines or is unable to notify the patient's next of kin may not have the patient's request for medication denied for that reason.
Written and Oral Requests.	To receive a prescription for medication that the qualified patient may self-administer under this Act, a qualified patient must make an oral request and a written request and reiterate the oral request to the qualified patient's attending physician at least 15 days after making the initial oral request. At the time the qualified patient makes the qualified patient's 2nd oral request, the attending physician shall offer the qualified patient an opportunity to rescind the request.

Maine

Right to Rescind Request.	A patient may rescind the patient's request at any time and in any manner without regard to the patient's mental state. A prescription for medication may not be written under this Act without the attending physician's offering the qualified patient an opportunity to rescind the request.
Waiting Periods.	At least 15 days must elapse between the patient's initial oral request and the date the patient signs the written request under subsection 11. At least 48 hours must elapse between the date the patient signs the written request and the writing of a prescription under this Act.
Medical Record Documentation Requirements.	The following must be documented or filed in a patient's medical record: A. All oral requests by the patient for medication to end that patient's life in a humane and dignified manner; B. All written requests by the patient for medication to end that patient's life in a humane and dignified manner; C. The attending physician's diagnosis and prognosis and the attending physician's determination that the patient is competent, is acting voluntarily and has made an informed decision; D. The consulting physician's diagnosis and prognosis and the consulting physician's verification that the patient is competent, is acting voluntarily and has made an informed decision; E. A report of the outcome and determinations made during counseling, if counseling is provided as described in subsection 8; F. The attending physician's offer to the patient to rescind the patient's request at the time of the patient's 2nd oral request under subsection 11; and G. A note by the attending physician indicating that all requirements under this Act have been met, including the requirements of subsection 6, and indicating the steps taken to carry out the patient's request, including a notation of the medication prescribed.
Residency Requirement.	For purposes of this Act, only requests made by residents of this State may be granted. The residence of a person is that place where the person has established a fixed and principal home to which the person, whenever temporarily absent, intends to return. The following factors may be offered in determining a person's residence under this Act and need not all be present in order to determine a person's residence: A. Possession of a valid driver's license issued by the Department of the Secretary of State, Bureau of Motor Vehicles; B. Registration to vote in this State; C. Evidence that the person owns or leases property in this State; D. The location of any dwelling currently occupied by the person; E. The place where any motor vehicle owned by the person is registered; F. The residence address, not a post office box, shown on a current income tax return; G. The residence address, not a post office box, at which the person's mail is received; H. The residence address, not a post office box, shown on any current resident hunting or fishing licenses held by the person;

	I. The residence address, not a post office box, shown on any driver's license held by the person; J. The receipt of any public benefit conditioned upon residency, defined substantially as provided in this subsection; or K. Any other objective facts tending to indicate a person's place of residence.
Disposal of Unused Medications.	A person who has custody of or control over any unused medications prescribed pursuant to this Act after the death of the qualified patient shall personally deliver the unused medications to the nearest facility qualified to dispose of controlled substances or, if such delivery is impracticable, personally dispose of the unused medications by any lawful means, in accordance with any guidelines adopted by the department.
Reporting of Information; Adoption of Rules; Information Collected not a Public Record; Annual Statistical Report.	The department shall: A. Annually review all records maintained under this Act; B. Require any health care provider upon writing a prescription or dispensing medication under this Act to file a copy of the prescription or dispensing record, and other documentation required under subsection 14 associated with writing the prescription or dispensing the medication, with the department. (1) Documentation required to be filed under this paragraph must be mailed or otherwise transmitted as allowed by rules of the department no later than 30 calendar days after the writing of the prescription or the dispensing of medication under this Act, except that all documents required to be filed with the department by the prescribing physician after the death of the qualified patient must be submitted no later than 30 calendar days after the date of the death of the qualified patient. (2) In the event that a person required under this Act to report information to the department provides an inadequate or incomplete report, the department shall contact the person to request an adequate or complete report; C. Within 6 months of the effective date of this Act, adopt rules, which are major substantive rules pursuant to Title 5, chapter 375, subchapter 2-A, to facilitate the collection of information regarding compliance with this Act. Except as otherwise provided by law, the information collected is confidential, is not a public record and may not be made available for inspection by the public; and D. Generate and make available to the public an annual statistical report of information collected under paragraph C and submit a copy of the report to the joint standing committee of the Legislature having jurisdiction over health matters annually by March 1st.
Effect on Construction of Wills, Contracts and Other Agreements.	Any provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, is not valid. Any obligation owing under any currently existing contract may not be conditioned upon or affected by the making or rescinding of a request by a person for medication to end the person's life in a humane and dignified manner.

Maine

Insurance or Annuity Policies.	The sale, procurement or issuance of any life, health or accident insurance or annuity policy or the rate charged for any life, health or accident insurance or annuity policy may not be conditioned upon or affected by the making or rescinding of a request by a qualified patient for medication that the patient may self-administer to end the patient's life in accordance with this Act. A qualified patient whose life is insured under a life insurance policy issued under the provisions of Title 24-A, chapter 29 and the beneficiaries of the policy may not be denied benefits on the basis of self-administration of medication by the qualified patient in accordance with this Act. The rating, sale, procurement or issuance of any medical professional liability insurance policy delivered or issued for delivery in this State must be in accordance with the provisions of Title 24-A.
Authority of Act; References to Acts Committed Under Act; Applicable Standard of Care.	This Act does not authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act do not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide under the law. State reports may not refer to acts committed under this Act as "suicide" or "assisted suicide." Consistent with the provisions of this Act, state reports must refer to acts committed under this Act as obtaining and self-administering life-ending medication. Nothing contained in this Act may be interpreted to lower the applicable standard of care for the attending physician, the consulting physician, a psychiatrist or a psychologist or other health care provider providing services under this Act.
Voluntary Participation.	Nothing in this Act requires a health care provider to provide medication to a qualified patient to end the qualified patient's life. If a health care provider is unable or unwilling to carry out the qualified patient's request under this Act, the health care provider shall transfer any relevant medical records for the patient to a new health care provider upon request by the patient.
Basis for Prohibiting Persons or Entities From Participation; Notification; Penalties; Permissible Actions.	The following provisions govern the basis for prohibiting persons or entities from participating in activities under this Act, notification, penalties and permissible actions. A. Subject to compliance with paragraph B and notwithstanding any other law, a health care provider may prohibit its employees, independent contractors or other persons or entities, including other health care providers, from participating in activities under this Act while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider. B. A health care provider that elects to prohibit its employees, independent contractors or other persons or entities, including other health care providers, from participating in activities under this Act, as described in paragraph A, shall first give notice of the policy prohibiting participation under this Act to those employees, independent contractors or other persons or entities, including other health care providers. A health care provider that fails to provide notice to those employees, independent contractors or other persons or entities, including other health care providers, in compliance with this paragraph may not enforce such a policy against those employees, independent contractors or other persons or entities, including other health care providers.

C. Subject to compliance with paragraph B, the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against an employee, independent contractor or other person or entity, including another health care provider, that violates this policy:

(1) Loss of privileges, loss of membership or other action authorized by the bylaws or rules and regulations of the medical staff;

(2) Suspension, loss of employment or other action authorized by the policies and practices of the prohibiting health care provider;

(3) Termination of any lease or other contract between the prohibiting health care provider and the employee, independent contractor or other person or entity, including another health care provider, that violates the policy; or

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the employee, independent contractor or other person or entity, including another health care provider, in violation of the policy.

D. Nothing in this section may be construed to prevent, or to allow a prohibiting health care provider to prohibit, an employee, independent contractor or other person or entity, including another health care provider, from any of the following:

(1) Participating, or entering into an agreement to participate, in activities under this Act while on premises that are not owned or under the management or direct control of the prohibiting health care provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider; or

(2) Participating, or entering into an agreement to participate, in activities under this Act as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting health care provider.

E. In taking actions pursuant to paragraph C, a health care provider shall comply with all procedures required by law, its own policies or procedures and any contract with the employee, independent contractor or other person or entity, including another health care provider, in violation of the policy, as applicable.

F. Any action taken by a prohibiting health care provider pursuant to this subsection is not reportable to the appropriate licensing board under Title 32, including, but not limited to, the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Maine Board of Pharmacy. The fact that a health care provider participates in activities under this Act may not be the sole basis for a complaint or report by another health care provider to the appropriate licensing board under Title 32, including, but not limited to, the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Maine Board of Pharmacy.

G. As used in this subsection, unless the context otherwise indicates, the following terms have the following meanings.

(1) "Notice" means a separate statement in writing advising of the prohibiting health care provider's policy with respect to participating in activities under this Act.

(2) "Participating, or entering into an agreement to participate, in activities under this Act" means doing or entering into an agreement to do any one or more of the following:

(a) Performing the duties of an attending physician as specified in this Act;

(b) Performing the duties of a consulting physician as specified in this Act;

(c) Performing the duties of a state-licensed psychiatrist, state-licensed psychologist, state-licensed clinical social worker or state-licensed clinical professional counselor, in the circumstance that a referral to one is made pursuant to subsection 8;

(d) Delivering the prescription for, dispensing or delivering the dispensed medication pursuant to this Act; or

(e) Being present when the qualified patient takes the medication prescribed pursuant to this Act.

"Participating, or entering into an agreement to participate, in activities under this Act" does not include doing, or entering into an agreement to do, any of the following: diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis or determining whether a patient has the capacity to make decisions; providing information to a patient about this Act; or providing a patient, upon the patient's request, with a referral to another health care provider for the purposes of participating in the activities authorized by this Act.

Claims by Governmental Entity for Costs Incurred.	Any governmental entity that incurs costs resulting from a person ending the person's life under this Act in a public place has a claim against the estate of the person to recover the costs and reasonable attorney's fees related to enforcing the claim.
Form of the Request.	*** Refer directly to statute for form of patient written request. ***
Form of Interpreter Attachment.	*** Refer directly to statute for form of interpreter attachment. ***

Short Title.

1. Sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) shall be known and may be cited as the “Medical Aid in Dying for the Terminally Ill Act.”

Findings, Declarations Relative to Medical Aid in Dying for the Terminally Ill.

2. The Legislature finds and declares that:

a. Recognizing New Jersey’s long-standing commitment to individual dignity, informed consent, and the fundamental right of competent adults to make health care decisions about whether to have life-prolonging medical or surgical means or procedures provided, withheld, or withdrawn, this State affirms the right of a qualified terminally ill patient, protected by appropriate safeguards, to obtain medication that the patient may choose to self-administer in order to bring about the patient’s humane and dignified death.

b. Statistics from other states that have enacted laws to provide compassionate medical aid in dying for terminally ill patients indicate that the great majority of patients who requested medication under the laws of those states, including more than 90 percent of patients in Oregon since 1998 and between 72 percent and 86 percent of patients in Washington in each year since 2009, were enrolled in hospice care at the time of death, suggesting that those patients had availed themselves of available treatment and comfort care options available to them at the time they requested compassionate medical aid in dying.

c. The public welfare requires a defined and safeguarded process in order to effectuate the purposes of this act, which will:

(1) guide health care providers and patient advocates who provide support to dying patients;

(2) assist capable, terminally ill patients who request compassionate medical aid in dying;

(3) protect vulnerable adults from abuse; and

(4) ensure that the process is entirely voluntary on the part of all participants, including patients and those health care providers that are providing care to dying patients.

d. This act is in the public interest and is necessary for the welfare of the State and its residents.

Definitions Relative to Medical Aid in Dying for the Terminally Ill.

3. As used in P.L.2019, c.59 (C.26:16-1 et al.):

“Adult” means an individual who is 18 years of age or older.

“Attending physician” means a physician licensed pursuant to Title 45 of the Revised Statutes who has primary responsibility for the treatment and care of a qualified terminally ill patient and treatment of the patient's illness, disease, or condition.

“Capable” means having the capacity to make health care decisions and to communicate them to a health care provider, including communication through persons familiar with the patient’s manner of communicating if those persons are available.

“Consulting physician” means a physician licensed pursuant to Title 45 of the Revised Statutes who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's illness, disease, or condition.

“Health care facility” means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

“Health care professional” means a person licensed to practice a health care profession pursuant to Title 45 of the Revised Statutes.

“Health care provider” means a health care professional or health care facility.

“Informed decision” means a decision by a qualified terminally ill patient to request and obtain a prescription for medication that the patient may choose to self-administer to end the patient’s life in a humane and dignified manner, which is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

(1) the patient’s medical diagnosis;

(2) the patient’s prognosis;

(3) the potential risks associated with taking the medication to be prescribed;

(4) the probable result of taking the medication to be prescribed; and

(5) 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.

"Long-term care facility" means a nursing home, assisted living residence, comprehensive personal care home, residential health care facility, or dementia care home licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

“Medically confirmed” means that the medical opinion of the attending physician has been confirmed pursuant to section 7 of P.L.2019, c.59 (C.26:16-7) by a consulting physician who has examined the patient and the patient's relevant medical records.

“Mental health care professional” means a psychiatrist, psychologist, or clinical social worker licensed pursuant to Title 45 of the Revised Statutes.

“Participate in this act” means to perform the duties of a health care provider in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.), but does not include: making an initial determination that a patient is terminally ill and informing the patient of the medical prognosis; providing information about the provisions of P.L.2019, c.59 (C.26:16-1 et al.) to a patient upon the patient’s request; or providing a patient, upon the patient’s request, with a referral to another health care provider.

“Patient” means a person who is under the care of a physician.

“Qualified terminally ill patient” means a capable adult who is a resident of New Jersey and has satisfied the requirements to obtain a prescription for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.). A person shall not be considered to be a qualified terminally ill patient solely because of the person’s age or disability or a diagnosis of any specific illness, disease, or condition.

“Self-administer” means a qualified terminally ill patient's act of physically administering, to the patient’s own self, medication that has been prescribed pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

“Terminally ill” means that the patient is in the terminal stage of an irreversibly fatal illness, disease, or condition with a prognosis, based upon reasonable medical certainty, of a life expectancy of six months or less.

Conditions for

4. A terminally ill patient may make a written request for medication that the patient may choose to self-administer

Request for Medication.	pursuant to P.L.2019, c.59 (C.26:16-1 et al.), if the patient: a. is an adult resident of New Jersey as demonstrated pursuant to section 11 of P.L.2019, c.59 (C.26:16-11); b. is capable and has been determined by the patient's attending physician and a consulting physician to be terminally ill; and c. has voluntarily expressed a wish to receive a prescription for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.).
Form for Valid Written Request for Medication.	5. a. A valid written request for medication under P.L.2019, c.59 (C.26:16-1 et al.) shall be in substantially the form set forth in section 20 of P.L.2019, c.59 (C.26:16-20), signed and dated by the patient and witnessed by at least two individuals who, in the patient's presence, attest that, to the best of their knowledge and belief, the patient is capable and is acting voluntarily to sign the request. b. At least one of the witnesses shall be a person who is not: (1) a relative of the patient by blood, marriage, or adoption; (2) at the time the request is signed, entitled to any portion of the patient's estate upon the patient's death under any will or by operation of law; and (3) an owner, operator, or employee of a health care facility, other than a long term care facility, where the patient is receiving medical treatment or is a resident. c. The patient's attending physician at the time the request is signed shall not serve as a witness.
Responsibilities of Attending Physician.	6. a. The attending physician shall ensure that all appropriate steps are carried out in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) before writing a prescription for medication that a qualified terminally ill patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.), including such actions as are necessary to: (1) make 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.); (2) require that the patient demonstrate New Jersey residency pursuant to section 11 of P.L.2019, c.59 (C.26:16-11); (3) inform the patient of: the patient's medical diagnosis and prognosis; the potential risks associated with taking the medication to be prescribed; the probable result of taking the medication to be prescribed; and 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; (4) refer 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; (5) refer the patient to a mental health care professional, if appropriate, pursuant to section 8 of P.L.2019, c.59 (C.26:16-8); (6) recommend 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 provide the patient

with a referral to a health care professional qualified to discuss these options with the patient;

(7) advise 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;

(8) inform the patient of the patient's opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind the request at the time the patient makes a second oral request as provided in section 10 of P.L.2019, c.59 (C.26:16-10); and

(9) fulfill the medical record documentation requirements of P.L.2019, c.59 (C.26:16-1 et al.).

b. The attending physician shall:

(1) dispense medication directly, including ancillary medication intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under law to dispense and has a current federal Drug Enforcement Administration certificate of registration; or

(2) contact a pharmacist to inform the latter of the prescription, and transmit the written prescription personally, by mail, or by permissible electronic communication to the pharmacist, who shall dispense the medication directly to either the patient, the attending physician, or an expressly identified agent of the patient.

Medication dispensed pursuant to this subsection shall not be dispensed to the patient by mail or other form of courier.

Conditions to be Considered Qualified Terminally Ill Patient.

7. A patient shall not be considered a qualified terminally ill patient until a consulting physician has:

a. examined that patient and the patient's relevant medical records;

b. confirmed, in writing, the attending physician's diagnosis that the patient is terminally ill; and

c. verified that the patient is capable, is acting voluntarily, and has made an informed decision to request medication that, if prescribed, the patient may choose to self -administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

Determination of Capability of Patient.

8. a. If, in the medical opinion of the attending physician or the consulting physician, a patient requesting medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.) may not be capable, the physician shall refer the patient to a mental health care professional to determine whether the patient is capable. A consulting physician who refers a patient to a mental health care professional pursuant to this subsection shall provide written notice of the referral to the attending physician.

b. If a patient has been referred to a mental health care professional pursuant to subsection a. of this section, the attending physician shall not write a prescription for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.) unless the attending physician has been notified in writing by the mental health care professional of that individual's determination that the patient is capable.

Notification of Next of Kin Required; Exception.

9. A qualified terminally ill patient shall not receive a prescription for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.) unless the attending physician has recommended that the patient notify the patient's next of kin of the patient's request for medication, except that a patient who declines or is

unable to notify the patient's next of kin shall not have the request for medication denied for that reason.

Oral, Written Request by Patient, Physician's Actions.

10. a. In order to receive a prescription for medication that a qualified terminally ill patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.), the patient shall make two oral requests and one written request for the medication to the patient's attending physician, subject to the following requirements:

(1) at least 15 days shall elapse between the initial oral request and the second oral request;

(2) at the time the patient makes a second oral request, the attending physician shall offer the patient an opportunity to rescind the request;

(3) the patient may submit the written request to the attending physician when the patient makes the initial oral request or at any time thereafter;

(4) the written request shall meet the requirements of section 5 of P.L.2019, c.59 (C.26:16-5);

(5) at least 15 days shall elapse between the patient's initial oral request and the writing of a prescription pursuant to P.L.2019, c.59 (C.26:16-1 et al.); and

(6) at least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

b. A qualified terminally ill patient may rescind the request at any time and in any manner without regard to the patient's mental state.

c. At the time the patient makes an initial oral request for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.), the patient's attending physician shall recommend to the patient that the patient participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options, and provide the patient with a referral to a health care professional qualified to discuss these options with the patient. If the patient chooses to participate in such consultation, the consultation shall include, to the extent the patient consents to share such information, consideration of: the patient's terminal illness; the patient's prognosis; current and past courses of treatment prescribed for the patient in connection with the patient's terminal illness, including the results of any such treatment; and any palliative care, comfort care, hospice care, and pain control treatment the patient is currently receiving or has received in the past.

d. The attending physician shall ensure that the following items are included in the patient's medical record:

(1) the determination that the patient is a qualified terminally ill patient and the basis for that determination;

(2) all oral and written requests by the patient to the attending physician for medication that the patient may choose to self-administer pursuant to P.L.2019, c.59 (C.26:16-1 et al.);

(3) the attending physician's diagnosis and prognosis, and determination that the patient is capable, is acting voluntarily, and has made an informed decision;

(4) the consulting physician's diagnosis and prognosis, and verification that the patient is capable, is acting voluntarily, and has made an informed decision;

(5) if applicable, a report of the determination made by a mental health care professional as to whether the patient is capable pursuant to section 8 of P.L.2019, c.59 (C.26:16-8);

(6) the attending physician's recommendation that the patient participate in a consultation concerning concurrent or additional treatment opportunities, palliative care, comfort care, hospice care, and pain control options; the referral provided to the patient with a referral to a health care professional qualified to discuss these options with the patient; an indication as to whether the patient participated in the consultation; and an indication as to whether the patient is currently receiving palliative care, comfort care, hospice care, or pain control treatments;

(7) the attending physician's offer to the patient to rescind the patient's request at the time of the patient's second oral request; and

(8) a note by the attending physician indicating that all requirements under P.L.2019, c.59 (C.26:16-1 et al.) have been met and indicating the steps taken to carry out the patient's request for medication, including a notation of the medication prescribed.

Documentation of New Jersey Residency.

11. A request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) shall not be granted unless the qualified terminally ill patient has documented that individual's New Jersey residency by furnishing to the attending physician a copy of one of the following:

a. a driver's license or non-driver identification card issued by the New Jersey Motor Vehicle Commission;

b. proof that the person is registered to vote in New Jersey;

c. a New Jersey resident gross income tax return filed for the most recent tax year; or

d. any other government record that the attending physician reasonably believes to demonstrate the individual's current residency in this State.

Disposal of Medication if Patients Chooses not to Self-Administer.

12. Any medication dispensed pursuant to P.L.2019, c.59 (C.26:16-1 et al.) that a qualified terminally ill patient chooses not to self-administer shall be disposed of by lawful means, including, but not limited to, disposing of the medication consistent with State and federal guidelines concerning disposal of prescription medications, or surrendering the medication to a prescription medication drop-off receptacle. The patient shall designate a person who shall be responsible for the lawful disposal of the medication.

Reporting of Information, Statistical Report.

13. a. The Commissioner of Health shall require that a health care professional report the following information to the Department of Health on a form and in a manner prescribed by regulation of the commissioner:

(1) No later than 30 days after the dispensing of medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.), the physician or pharmacist who dispensed the medication shall file a copy of the dispensing record with the department, and shall otherwise facilitate the collection of such information as the director may require regarding compliance with P.L.2019, c.59 (C.26:16-1 et al.).

(2) No later than 30 days after the date of the qualified terminally ill patient's death, the attending physician shall transmit to the department such documentation of the patient's death as the director shall require.

(3) In the event that anyone required to report information to the department pursuant to P.L.2019, c.59 (C.26:16-1 et al.) provides an inadequate or incomplete report, the department shall contact the person to request a complete

report.

(4) To the maximum extent practicable and consistent with the purposes of this section, the department shall seek to coordinate the process for reporting information pursuant to this subsection with the process for reporting prescription monitoring information by a pharmacy permit holder pursuant to sections 25 through 30 of P.L.2007, c.244 (C.45:1-45 through C.45:1-50).

b. Any information collected pursuant to subsection a. of this section that contains material or data that could be used to identify an individual patient or health care professional shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.) and P.L.2001, c.404 (C.47:1A-5 et al.).

c. The department shall prepare and make available to the public on its Internet website an annual statistical report of information collected pursuant to subsection a. of this section.

Provisions in Certain Documents Would Not Restrict Request for Medication.

14. a. A provision in a contract, will, insurance policy, annuity, or other agreement, whether written or oral, made on or after the effective date of P.L.2019, c.59 (C.26:16-1 et al.), shall not be valid to the extent that the provision would condition or restrict a person's decision to make or rescind a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

b. An obligation owing under a contract, will, insurance policy, annuity, or other agreement, made before the effective date of P.L.2019, c.59 (C.26:16-1 et al.), shall not be affected by: the provisions of P.L.2019, c.59 (C.26:16-1 et al.); a person's making or rescinding a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.); or any other action taken pursuant to P.L.2019, c.59 (C.26:16-1 et al.).

c. On or after the effective date of P.L.2019, c.59 (C.26:16-1 et al.), procurement or issuance of a life, health, or accident insurance policy or annuity, or the premium or rate charged for the policy or annuity, shall not be conditioned upon or otherwise take into account the making or rescinding of a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) by any person.

Construction of Act.

15. Nothing in P.L.2019, c.59 (C.26:16-1 et al.) shall be construed to:

a. authorize a physician or any other person to end a patient's life by lethal injection, active euthanasia, or mercy killing, or any act that constitutes assisted suicide under any law of this State; or

b. lower the applicable standard of care to be provided by a health care professional who participates in P.L.2019, c.59 (C.26:16-1 et al.).

Certain Persons Not Authorized to Take Action on Behalf of Patient.

16. A person shall not be authorized to take any action on behalf of a patient for the purposes of P.L.2019, c.59 (C.26:16-1 et al.) by virtue of that person's designation as a guardian pursuant to N.J.S.3B:12-1 et seq., a conservator pursuant to N.J.S.3B:13A-1 et seq., a health care representative pursuant to P.L.1991, c.201 (C.26:2H-53 et seq.), or a patient's representative pursuant to P.L.2011, c.145 (C.26:2H-129 et al.), except for communicating the patient's health care decisions to a health care provider if the patient so requests.

Immunity.	17. a. (1) Except as provided in sections 18 and 19 of P.L.2019, c.59 (C.26:16-18 and C.26:16-19), a person shall not be subject to civil or criminal liability or professional disciplinary action, or subject to censure, discipline, suspension, or loss of any licensure, certification, privileges, or membership, for any action taken in compliance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.), including being present when a qualified terminally ill patient self-administers medication prescribed pursuant to P.L.2019, c.59 (C.26:16-1 et al.), or for the refusal to take any action in furtherance of, or to otherwise participate in, a request for medication pursuant to the provisions of P.L.2019, c.59 (C.26:16-1 et al.). A person who substantially complies in good faith with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall be deemed to be in compliance with its provisions. (2) Any action taken in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall not constitute patient abuse or neglect, suicide, assisted suicide, mercy killing, euthanasia, or homicide under any law of this State. (3) A patient's request for, or the provision of, medication in compliance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall not constitute abuse or neglect of an elderly person or provide the sole basis for the appointment of a guardian or conservator. b. The provisions of subsection a. of this section shall not apply to acts or omissions constituting gross negligence, recklessness, or willful misconduct. c. Any action taken by a health care professional to participate in P.L.2019, c.59 (C.26:16-1 et al.) shall be voluntary on the part of that individual. If a health care professional is unable or unwilling to carry out a patient's request under P.L.2019, c.59 (C.26:16-1 et al.), and the patient transfers the patient’s care to a new health care professional or health care facility, the prior health care professional shall transfer, upon request, a copy of the patient's relevant records to the new health care professional or health care facility.
Violations, Degree of Crime.	18. a. A person who, without authorization of the patient, and with the intent or effect of causing the patient’s death, willfully alters or forges a request for medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) or conceals or destroys a rescission of that request, is guilty of a crime of the second degree. b. A person who coerces or exerts undue influence on a patient to request medication pursuant to P.L.2019, c.59 (C.26:16-1 et al.) or to destroy a rescission of a request is guilty of a crime of the third degree. c. Theft of medication prescribed to a qualified terminally ill patient pursuant to P.L.2019, c.59 (C.26:16-1 et al.) shall constitute an offense involving theft of a controlled dangerous substance as set forth in N.J.S.2C:20-2. d. Nothing in P.L.2019, c.59 (C.26:16-1 et al.) shall limit liability for civil damages resulting from the negligence or intentional misconduct of any person. e. The penalties set forth in this section shall not preclude the imposition of any other criminal penalty applicable under law for conduct that is inconsistent with the provisions of P.L.2019, c.59 (C.26:16-1 et al.).
Claims by Governmental Entity, Certain Circumstances.	19. Any governmental entity that incurs costs resulting from a qualified terminally ill patient choosing to self-administer medication prescribed pursuant to P.L.2019, c.59 (C.26:16-1 et al.) in a public place has a claim against the estate of the patient to recover those costs and reasonable attorneys' fees related to enforcing the claim.

Form for Request of Medication.	*** Refer directly to statute for form of patient written request. ***
Rules, Regulations.	21. The Director of the Division of Consumer Affairs in the Department of Law and Public Safety, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.), including the required reporting of information to the division by health care professionals pursuant to section 13 of P.L.2019, c.59 (C.26:16-13).
State Board of Medical Examiners; Rules, Regulations.	22. The State Board of Medical Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed physician pursuant thereto.
New Jersey State Board of Pharmacy; Rules, Regulations.	23. The New Jersey State Board of Pharmacy, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed pharmacist pursuant thereto.
State Board of Psychological Examiners; Rules, Regulations.	24. The State Board of Psychological Examiners, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed psychologist pursuant thereto.
State Board of Social Work Examiners; Rules, Regulations.	25. The State Board of Social Work Examiners, pursuant to the “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) concerning the duties of a licensed clinical social worker pursuant thereto.
Definitions Relative to Actions by Health Care Facilities.	26. a. As used in this section: “Health care facility” or “facility” means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). “Health care professional” means a person licensed to practice a health care profession pursuant to Title 45 of the Revised statutes. b. (1) The existing policies and procedures utilized by a health care facility shall, to the maximum extent possible, govern the taking of any action by a health care professional pursuant to sections 1 through 20 of P.L.2019, c.59

(C.26:16-1 et seq.) on the premises owned by, or under the direct control of, the facility, except as otherwise prescribed by regulation of the Commissioner of Health pursuant to paragraph (4) of this subsection.

(2) Any action taken by a health care facility to participate in P.L.2019, c.59 (C.26:16-1 et al.) shall be voluntary on the part of the facility.

(3) A health care facility shall not be subject to a licensure enforcement action by the Department of Health for any action taken in compliance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.).

(4) The Commissioner of Health, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), shall adopt such rules and regulations as are necessary to implement the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.), concerning their application to a health care facility and any action taken by a health care professional on the premises owned by, or under the direct control of, the facility.

(5) The provisions of this subsection shall not preclude a health care facility or health care professional from providing to a patient any health care services to which the provisions of sections 1 through 20 of P.L.2019, c.59 (C.26:16-1 et seq.) do not apply.

27. Section 1 of P.L.1991, c.270 (C.2A:62A-16) is amended to read as follows:

Health Care Professionals, Immunity from Civil Liability; Duty to Warn and Protect.

27. Section 1 of P.L.1991, c.270 (C.2A:62A-16) is amended to read as follows:

1. a. Any person who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work, or marriage and family therapy, whether or not compensation is received or expected, is immune from any civil liability for a patient's violent act against another person or against himself unless the practitioner has incurred a duty to warn and protect the potential victim as set forth in subsection b. of this section and fails to discharge that duty as set forth in subsection c. of this section.

b. A duty to warn and protect is incurred when the following conditions exist:

(1) The patient has communicated to that practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out the threat; or

(2) The circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out an act of imminent, serious physical violence against a readily identifiable individual or against himself.

A duty to warn and protect shall not be incurred when a qualified terminally ill patient requests medication that the patient may choose to self-administer in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.).

c. A licensed practitioner of psychology, psychiatry, medicine, nursing, clinical social work, or marriage and family therapy shall discharge the duty to warn and protect as set forth in subsection b. of this section by doing one or more of the following:

(1) Arranging for the patient to be admitted voluntarily to a psychiatric unit of a general hospital, a short-term care facility, a special psychiatric hospital, or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(2) Initiating procedures for involuntary commitment to treatment of the patient to an outpatient treatment provider, a short-term care facility, a special psychiatric hospital, or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);

(3) Advising a local law enforcement authority of the patient's threat and the identity of the intended victim;

(4) Warning the intended victim of the threat, or, in the case of an intended victim who is under the age of 18, warning the parent or guardian of the intended victim; or

(5) If the patient is under the age of 18 and threatens to commit suicide or bodily injury upon himself, warning the parent or guardian of the patient.

d. A practitioner who is licensed in the State of New Jersey to practice psychology, psychiatry, medicine, nursing, clinical social work, or marriage and family therapy who, in complying with subsection c. of this section, discloses a privileged communication, is immune from civil liability in regard to that disclosure.

e. In addition to complying with subsection c. of this section, a licensed practitioner shall notify the chief law enforcement officer of the municipality in which the patient resides or the Superintendent of State Police if the patient resides in a municipality that does not have a full-time police department that a duty to warn and protect has been incurred with respect to the patient and shall provide to the chief law enforcement officer or superintendent, as appropriate, the patient’s name and other non-clinical identifying information. The chief law enforcement officer or superintendent, as appropriate, shall use that information to ascertain whether the patient has been issued a firearms purchaser identification card, permit to purchase a handgun, or any other permit or license authorizing possession of a firearm.

If the patient has been issued a firearms purchaser identification card, permit to purchase a handgun, or any other permit or license authorizing possession of a firearm, or if there is information indicating that the patient otherwise may have access to a firearm, the information provided may be used in determining whether the patient has become subject to any of the disabilities set forth in subsection c. of N.J.S.2C:58-3. If the chief law enforcement officer or superintendent, as appropriate, determines that the patient has become subject to any of the disabilities set forth in subsection c. of N.J.S.2C:58-3, any identification card or permit issued to the patient shall be void and subject to revocation by the Superior Court in accordance with the procedure established in subsection f. of N.J.S.2C:58-3.

If the court determines that the patient is subject to any of the disabilities set forth in subsection c. of N.J.S.2C:58-3 and revokes the patient’s firearms purchaser identification card in accordance with the procedure established in subsection f. of N.J.S.2C:58-3, the court may order the patient to surrender to the county prosecutor any firearm owned by or accessible to the patient and order the prosecutor to dispose of the firearms. When the court orders the county prosecutor to dispose of the firearms, the prosecutor shall dispose of the firearms as provided in N.J.S.2C:64-6.

If the court, upon motion of the prosecutor, finds probable cause that the patient has failed to surrender any firearm, card, or permit, the court may order a search for and removal of these items at any location where the judge has reasonable cause to believe these items are located. The judge shall state with specificity the reasons and the scope of the search and seizure authorized by the order.

A firearm surrendered or seized pursuant to this subsection which is not legally owned by the patient shall be immediately returned to the legal owner of the firearm if the legal owner submits a written request to the prosecutor

attesting that the patient does not have access to the firearm.
A law enforcement officer or agency shall not be held liable in any civil action brought by any person for failing to learn of, locate, or seize a firearm pursuant to this subsection.
A patient who is determined to be subject to any of the disabilities established in paragraph (3) of subsection c. of N.J.S.2C:58-3 and submits a certificate of a medical doctor or psychiatrist licensed in New Jersey, or other satisfactory proof in accordance with that paragraph shall be entitled to the reinstatement of any firearms purchaser identification cards, permits to purchase a handgun, and any other permit or license authorizing possession of a firearm seized pursuant to this subsection.

Aiding Suicide.

28. N.J.S.2C:11-6 is amended to read as follows:
2C:11-6. Aiding Suicide. A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree. Any action taken in accordance with the provisions of P.L.2019, c.59 (C.26:16-1 et al.) shall not constitute suicide or assisted suicide.

Short Title.

Chapter 24, Article 7C NMSA 1978 may be cited as the "End-of-Life Options Act" or the "Elizabeth Whitefield End-of-Life Options Act".
History: Laws 2021, ch. 132, § 1; 2023, ch. 133, § 1.

Definitions.

As used in the End-of-Life Options Act:
A. "adult" means a resident of the state who is eighteen years of age or older;
B. "capacity" means an individual's ability to understand and appreciate health care options available to that individual, including significant benefits and risks, and to make and communicate an informed health care decision. A determination of capacity shall be made only according to professional standards of care and the provisions of Section 24-7A-11 NMSA 1978;
C. "health care entity" means an entity, other than an individual, that is licensed to provide any form of health care in the state, including a hospital, clinic, hospice agency, home health agency, long-term care agency, pharmacy, group medical practice, medical home or any similar entity;
D. "health care provider" means any of the following individuals authorized pursuant to the New Mexico Drug, Device and Cosmetic Act [Chapter 26, Article 1 NMSA 1978] to prescribe a medication to be used in medical aid in dying:
(1) a physician licensed pursuant to the Medical Practice Act [Chapter 61, Article 6 NMSA 1978];
(2) an osteopathic physician licensed pursuant to the Osteopathic Medicine Act [Chapter 61, Article 10 NMSA 1978];
(3) a nurse licensed in advanced practice pursuant to the Nursing Practice Act [Chapter 61, Article 3 NMSA 1978]; or
(4) a physician assistant licensed pursuant to the Physician Assistant Act [61-6-7 to 61-6-10 NMSA 1978] or the Osteopathic Medicine Act;
E. "medical aid in dying" means the medical practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to bring about a peaceful death;
F. "mental health professional" means a state-licensed psychiatrist, psychologist, master social worker, psychiatric nurse practitioner or professional clinical mental health counselor;
G. "prescribing health care provider" means a health care provider who prescribes medical aid in dying medication;
H. "qualified individual" means an individual who has met the requirements of Section 3 [24-7C-3 NMSA 1978] of the End-of-Life Options Act;
I. "self-administer" means taking an affirmative, conscious, voluntary action to ingest a pharmaceutical substance; and
J. "terminal illness" means a disease or condition that is incurable and irreversible and that, in accordance with reasonable medical judgment, will result in death within six months.
History: Laws 2021, ch. 132, § 2.

Medical Aid in Dying--

A prescribing health care provider may provide a prescription for medical aid in dying medication to an individual only

Prescribing Health Care Provider Determination--Form.	after the prescribing health care provider has: A. determined that the individual has: (1) capacity; (2) a terminal illness; (3) voluntarily made the request for medical aid in dying; and (4) the ability to self-administer the medical aid in dying medication; B. provided medical care to the individual in accordance with accepted medical standards of care; C. determined that the individual is making an informed decision after discussing with the individual the: (1) individual's medical diagnosis and prognosis; (2) potential risks associated with self-administering the medical aid in dying medication that the individual has requested the health care provider to prescribe; (3) probable result of self-administering the medical aid in dying medication to be prescribed; (4) individual's option of choosing to obtain the medical aid in dying medication and then deciding not to use it; and (5) feasible alternative, concurrent or additional treatment opportunities, including hospice care and palliative care focused on relieving symptoms and reducing suffering; D. determined in good faith that the individual's request does not arise from coercion or undue influence by another person; E. noted in the individual's health record the prescribing health care provider's determination that the individual qualifies to receive medical aid in dying; F. confirmed in the individual's health record that at least one physician or osteopathic physician licensed pursuant to the Medical Practice Act [Chapter 61, Article 6 NMSA 1978] or the Osteopathic Medicine Act [Chapter 61, Article 10 NMSA 1978] has determined, after conducting an appropriate examination, that the individual has capacity, a terminal illness and the ability to self-administer the medical aid in dying medication. That physician may be the prescribing health care provider pursuant to this section, the individual's hospice health care provider or another physician who meets the requirements of this subsection; G. affirmed that the individual is: (1) enrolled in a medicare-certified hospice program; or (2) eligible to receive medical aid in dying after the prescribing health care provider has referred the individual to a consulting health care provider, who has experience with the underlying condition rendering the qualified individual terminally ill, and the consulting health care provider has: (a) examined the individual; (b) reviewed the individual's relevant medical records; and (c) confirmed, in writing, the prescribing health care provider's prognosis that the individual is suffering from a terminal illness; and H. provided substantially the following form to the individual and enters the form into the individual's health record after the form has been completed with all of the required signatures and initials: *** Refer directly to statute for form of patient written request. **

	History: Laws 2021, ch. 132, § 3.
Medical Aid in Dying--Prescribing Health Care Provider Determination--Form.	*** Refer directly to statute for form of patient written request. ***
Determining Capacity.	If an individual has a recent history of a mental health disorder or an intellectual disability that could cause impaired judgment with regard to end-of-life medical decision making, or if, in the opinion of the prescribing health care provider or consulting health care provider, an individual currently has a mental health disorder or an intellectual disability that may cause impaired judgment with regard to end-of-life medical decision making, the individual shall not be determined to have capacity to make end-of-life decisions until the: A. health care provider refers the individual for evaluation by a mental health professional with the training and expertise to assess a person with such a disorder or disability; and B. mental health professional determines the individual to have capacity to make end-of-life decisions after evaluating the individual during one or more visits with the individual. History: Laws 2021, ch. 132, § 4.
Waiting Periods.	A prescription for medical aid in dying medication shall: A. not be filled until forty-eight hours after the prescription for medical aid in dying medication has been written, unless the qualified individual's prescribing health care provider has medically confirmed that the qualified individual may, within reasonable medical judgment, die before the expiration of the waiting period identified herein, in which case, the prescription may be filled once the prescribing health care provider affirms that all requirements have been fulfilled pursuant to Section 3 [24-7C-3 NMSA 1978] of the End-of-Life Options Act; and B. indicate the date and time that the prescription for medical aid in dying medication was written and indicate the first allowable date and time when it may be filled. History: Laws 2021, ch. 132, § 5.
Medical Aid in Dying--Right to Know.	A health care provider shall inform a terminally ill patient of all reasonable options related to the patient's care that are legally available to terminally ill patients that meet the medical standards of care for end-of-life care. History: Laws 2021, ch. 132, § 6.
Immunities--Conscience-Based Decisions.	A. A person shall not be subject to criminal liability, licensing sanctions or other professional disciplinary action for: (1) participating in medical aid in dying in good faith compliance with the provisions of the End-of-Life Options Act;

(2) being present when a qualified patient self-administers the prescribed medical aid in dying medication to end the qualified individual's life in accordance with the provisions of the End-of-Life Options Act; or

(3) refusing, for reasons of conscience, to participate in medical aid in dying in any way, which includes refusing to provide information on medical aid in dying to a patient and refusing to refer a patient to any entity or individual who is able and willing to assist the patient in obtaining medical aid in dying.

B. A health care entity, health insurer, managed care organization or health care provider shall not subject a person to censure, discipline, suspension, loss or denial of license, credential, privileges or membership or other penalty for participating, or refusing to participate, in the provision of medical aid in dying in good faith compliance with the provisions of the End-of-Life Options Act.

C. No health care provider who objects for reasons of conscience to participating in the provision of medical aid in dying shall be required to participate in the provision of medical aid in dying under any circumstance. If a health care provider is unable or unwilling to carry out an individual's request pursuant to the End-of-Life Options Act, that health care provider shall so inform the individual and refer the individual to a health care provider who is able and willing to carry out the individual's request or to another individual or entity to assist the requesting individual in seeking medical aid in dying. If the health care provider transfers the individual's care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the individual's relevant medical records to the new health care provider.

D. A health care entity shall not forbid or otherwise sanction a health care provider who provides medical aid in dying in accordance with the End-of-Life Options Act off the premises of the health care entity or when the health care provider is not acting within the normal course and scope of the health care provider's employment with the health care entity.

E. A health care entity may sanction a health care provider for participating in medical aid in dying on the premises of the prohibiting health care entity only if the health care entity has given written notice to the health care provider of the prohibiting entity's written policy forbidding participation in medical aid in dying and the health care provider participates in medical aid in dying:

(1) on the premises of the health care entity; or

(2) within the course and scope of the health care provider's employment for the health care entity.

F. Nothing in this section shall be construed to prevent:

(1) a health care provider from participating in medical aid in dying while the health care provider is acting outside the health care entity's premises or outside the course and scope of the health care provider's capacity as an employee; or

(2) an individual who seeks medical aid in dying from contracting with the individual's prescribing health care provider or consulting health care provider to act outside the course and scope of the provider's affiliation with the sanctioning health care entity.

G. A health care entity that imposes sanctions on a health care provider pursuant to the End-of-Life Options Act shall act reasonably, both substantively and procedurally, and shall be neither arbitrary nor capricious in its imposition of sanctions.

H. Participating, or not participating, in medical aid in dying shall not be the basis for a report of unprofessional conduct.

I. A health care entity that prohibits medical aid in dying shall accurately and clearly articulate this in an appropriate

location on any website maintained by the entity and in any appropriate materials given to patients to whom the health care entity provides health care in words to be determined by the health care entity.
History: Laws 2021, ch. 132, § 7; 2023, ch. 133, § 2

Prohibited Acts.

Nothing in the End-of-Life Options Act shall be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing or euthanasia. Actions taken in accordance with the End-of-Life Options Act shall not be construed, for any purpose, to constitute suicide, assisted suicide, euthanasia, mercy killing, homicide or adult abuse under the law.
History: Laws 2021, ch. 132, § 8.

Reporting--Medical Aid in Dying.

A. A health care provider who prescribes medical aid in dying to a qualified individual in accordance with the provisions of the End-of-Life Options Act [24-7C-1 to 24-7C-8 NMSA 1978] shall provide, in accordance with department rules, a report of that provider's participation. The department shall adopt and promulgate rules that establish the time frames and forms for reporting pursuant to this section and shall limit the reporting of data relating to qualified individuals who received prescriptions for medical aid in dying medication to the following:
(1) the qualified individual's age at death;
(2) the qualified individual's race and ethnicity;
(3) the qualified individual's gender;
(4) whether the qualified individual was enrolled in hospice at the time of death;
(5) the qualified individual's underlying medical condition; and
(6) whether the qualified individual self-administered the medical aid in dying medication and, if so, the date that this occurred.
B. The department shall promulgate an annual statistical report, containing aggregated data, on the information collected pursuant to Subsection A of this section on the total number of medical aid in dying medication prescriptions written statewide and on the number of health care providers who have issued prescriptions for medical aid in dying medication during that year. Data reported pursuant to this subsection shall not contain individually identifiable health information and are exempt from disclosure pursuant to the Inspection of Public Records Act [Chapter 14, Article 3 NMSA 1978].
C. As used in this section:
(1) "health care provider" means an individual authorized pursuant to the End-of-Life Options Act to prescribe medical aid in dying;
(2) "medical aid in dying" means the medical practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to end that individual's life in accordance with the provisions of the End-of-Life Options Act; and
(3) "qualified individual" means an individual who has met the requirements to receive medical aid in dying pursuant to the provisions of the End-of-Life Options Act.

History: Laws 2021, ch. 132, § 9.

127.800 §1.01. Definitions.	The following words and phrases, whenever used in ORS 127.800 to 127.897, have the following meanings: (1) "Adult" means an individual who is 18 years of age or older. (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease. (3) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. (4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease. (5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. (6) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility. (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of: (a) His or her medical diagnosis; (b) His or her prognosis; (c) The potential risks associated with taking the medication to be prescribed; (d) The probable result of taking the medication to be prescribed; and (e) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control. (8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records. (9) "Patient" means a person who is under the care of a physician. (10) "Physician" means a doctor licensed to practice medicine under ORS 677.100 to 677.228. (11) "Qualified patient" means a capable adult who has satisfied the requirements of ORS 127.800 to 127.897 in order to obtain a prescription for medication to end his or her life in a humane and dignified manner. (12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months. [1995 c.3 §1.01; 1999 c.423 §1; 2017 c.409 §3]
127.805 §2.01. Who may initiate a written request for	(1) An adult who is capable and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS

medication.	127.800 to 127.897. (2) No person shall qualify under the provisions of ORS 127.800 to 127.897 solely because of age or disability. [1995 c.3 §2.01; 1999 c.423 §2]
127.810 §2.02. Form of the written request.	(1) A valid request for medication under ORS 127.800 to 127.897 shall be in substantially the form described in ORS 127.897, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request. (2) One of the witnesses shall be a person who is not: (a) A relative of the patient by blood, marriage or adoption; (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident. (3) The patient's attending physician at the time the request is signed shall not be a witness. (4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Oregon Health Authority by rule. [1995 c.3 §2.02]
127.815 §3.01. Attending physician responsibilities.	(1) The attending physician shall: (a) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily; (b) To ensure that the patient is making an informed decision, inform the patient of: (A) His or her medical diagnosis; (B) His or her prognosis; (C) The potential risks associated with taking the medication to be prescribed; (D) The probable result of taking the medication to be prescribed; and (E) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control; (c) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily; (d) Refer the patient for counseling if appropriate pursuant to ORS 127.825; (e) Recommend that the patient notify next of kin; (f) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed pursuant to ORS 127.800 to 127.897 and of not taking the medication in a public place; (g) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the time the patient makes the patient’s second oral request pursuant to

ORS 127.840;

(h) Verify, immediately prior to writing the prescription for medication under ORS 127.800 to 127.897, that the patient is making an informed decision;

(i) Fulfill the medical record documentation requirements of ORS 127.855;

(j) Ensure that all appropriate steps are carried out in accordance with ORS 127.800 to 127.897 prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(k)(A) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, provided the attending physician is registered as a dispensing physician with the Board of Medical Examiners, has a current Drug Enforcement Administration certificate and complies with any applicable administrative rule; or

(B) With the patient's written consent:

(i) Contact a pharmacist and inform the pharmacist of the prescription; and

(ii) Deliver the written prescription personally or by mail to the pharmacist, who will dispense the medications to either the patient, the attending physician or an expressly identified agent of the patient.

(2) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate. [1995 c.3 §3.01; 1999 c.423 §3; 2013 c.366 §62; 2019 c.624 §1]

Consulting Physician Confirmation.

Before a patient is qualified under ORS 127.800 to 127.897, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision. [1995 c.3 §3.02]

127.825 §3.03. Counseling referral.

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [1995 c.3 §3.03; 1999 c.423 §4]

127.830 §3.04. Informed decision.

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in ORS 127.800 (7). Immediately prior to writing a prescription for medication under ORS 127.800 to 127.897, the attending physician shall verify that the patient is making an informed decision. [1995 c.3 §3.04]

127.835 §3.05. Family notification.

The attending physician shall recommend that the patient notify the next of kin of his or her request for medication pursuant to ORS 127.800 to 127.897. A patient who declines or is unable to notify next of kin shall not have his or her

request denied for that reason. [1995 c.3 §3.05; 1999 c.423 §6]

127.840 §3.06. Written and oral requests.

(1) In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than 15 days after making the initial oral request.
(2) Notwithstanding subsection (1) of this section, if the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die within 15 days after making the initial oral request under this section, the qualified patient may reiterate the oral request to his or her attending physician at any time after making the initial oral request.
(3) At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request. [1995 c.3 §3.06; 2019 c.624 §2]

127.845 §3.07. Right to rescind request.

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under ORS 127.800 to 127.897 may be written without the attending physician offering the qualified patient an opportunity to rescind the request. [1995 c.3 §3.07]

127.850 §3.08. Waiting periods.

(1) No less than 15 days shall elapse between the patient's initial oral request and the writing of a prescription under ORS 127.800 to 127.897. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under ORS 127.800 to 127.897. [1995 c.3 §3.08]
(2) Notwithstanding subsection (1) of this section, if the qualified patient's attending physician has medically confirmed that the qualified patient will, within reasonable medical judgment, die before the expiration of at least one of the waiting periods described in subsection (1) of this section, the prescription for medication under ORS 127.800 to 127.897 may be written at any time following the later of the qualified patient's written request or second oral request under ORS 127.840. [1995 c.3 §3.08; 2019 c.624 §3]

127.855 §3.09. Medical record documentation requirements.

The following shall be documented or filed in the patient's medical record:
(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
(5) A report of the outcome and determinations made during counseling, if performed;
(6) Any medically confirmed certification of the imminence of the patient's death;
(7) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral

	request pursuant to ORS 127.840; and (8) A note by the attending physician indicating that all requirements under ORS 127.800 to 127.897 have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed. [1995 c.3 §3.09; 2019 c.624 §4]
127.865 §3.11. Reporting requirements.	(1)(a) The Oregon Health Authority shall annually review a sample of records maintained pursuant to ORS 127.800 to 127.897. (b) The authority shall require any health care provider upon dispensing medication pursuant to ORS 127.800 to 127.897 to file a copy of the dispensing record with the division. (2) The authority shall make rules to facilitate the collection of information regarding compliance with ORS 127.800 to 127.897. Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public. (3) The authority shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section. [1995 c.3 §3.11; 1999 c.423 §9; 2001 c.104 §40; 2009 c.595 §89]
127.870 §3.12. Effect on construction of wills, contracts and statutes.	(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid. (2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [1995 c.3 §3.12]
127.875 §3.13. Insurance or Annuity Policies.	The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy. [1995 c.3 §3.13]
127.880 §3.14 Construction of Act.	Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with ORS 127.800 to 127.897 shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law. [1995 c.3 §3.14]
127.885 §4.01. Immunities; Basis for Prohibiting Health	Except as provided in ORS 127.890: (1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with ORS 127.800 to 127.897. This includes being present when a qualified patient takes the prescribed

Care Provider from Participation; Notification; Permissible Sanctions.

medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with ORS 127.800 to 127.897.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of ORS 127.800 to 127.897 shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under ORS 127.800 to 127.897, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(5)(a) Notwithstanding any other provision of law, a health care provider may prohibit another health care provider from participating in ORS 127.800 to 127.897 on the premises of the prohibiting provider if the prohibiting provider has notified the health care provider of the prohibiting provider's policy regarding participating in ORS 127.800 to 127.897. Nothing in this paragraph prevents a health care provider from providing health care services to a patient that do not constitute participation in ORS 127.800 to 127.897.

(b) Notwithstanding the provisions of subsections (1) to (4) of this section, a health care provider may subject another health care provider to the sanctions stated in this paragraph if the sanctioning health care provider has notified the sanctioned provider prior to participation in ORS 127.800 to 127.897 that it prohibits participation in ORS 127.800 to 127.897:

(A) Loss of privileges, loss of membership or other sanction provided pursuant to the medical staff bylaws, policies and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in ORS 127.800 to 127.897 while on the health care facility premises, as defined in ORS 442.015, of the sanctioning health care provider, but not including the private medical office of a physician or other provider;

(B) Termination of lease or other property contract or other nonmonetary remedies provided by lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in ORS 127.800 to 127.897 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(C) Termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in ORS 127.800 to 127.897 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subparagraph shall be construed to prevent:

(i) A health care provider from participating in ORS 127.800 to 127.897 while acting outside the course and scope of the provider's capacity as an employee or independent contractor; or

(ii) A patient from contracting with his or her attending physician and consulting physician to act outside the

course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(c) A health care provider that imposes sanctions pursuant to paragraph (b) of this subsection must follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For purposes of this subsection:

(A) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider prior to the provider's participation in ORS 127.800 to 127.897 of the sanctioning health care provider's policy about participation in activities covered by ORS 127.800 to 127.897.

(B) "Participate in ORS 127.800 to 127.897" means to perform the duties of an attending physician pursuant to ORS 127.815, the consulting physician function pursuant to ORS 127.820 or the counseling function pursuant to ORS 127.825. "Participate in ORS 127.800 to 127.897" does not include:

(i) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(ii) Providing information about the Oregon Death with Dignity Act to a patient upon the request of the patient;

(iii) Providing a patient, upon the request of the patient, with a referral to another physician; or

(iv) A patient contracting with his or her attending physician and consulting physician to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(6) Suspension or termination of staff membership or privileges under subsection (5) of this section is not reportable under ORS 441.820. Action taken pursuant to ORS 127.810, 127.815, 127.820 or 127.825 shall not be the sole basis for a report of unprofessional or dishonorable conduct under ORS 677.415 (3), (4), (5), or (6).

(7) No provision of ORS 127.800 to 127.897 shall be construed to allow a lower standard of care for patients in the community where the patient is treated or a similar community. [1995 c.3 §4.01; 1999 c.423 §10; 2003 c.554 §3]

Note: As originally enacted by the people, the leadline to section 4.01 read "Immunities." The remainder of the leadline was added by editorial action.

127.890 §4.02. Liabilities.

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in ORS 127.800 to 127.897 limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in ORS 127.800 to 127.897 do not preclude criminal penalties applicable under other law for conduct

	which is inconsistent with the provisions of ORS 127.800 to 127.897. [1995 c.3 §4.02]
Claims by Governmental Entity for Costs Incurred.	Any governmental entity that incurs costs resulting from a person terminating his or her life pursuant to the provisions of ORS 127.800 to 127.897 in a public place shall have a claim against the estate of the person to recover such costs and reasonable attorney fees related to enforcing the claim. [1999 c.423 §5a]
127.895 §5.01. Severability.	Any section of ORS 127.800 to 127.897 being held invalid as to any person or circumstance shall not affect the application of any other section of ORS 127.800 to 127.897 which can be given full effect without the invalid section or application. [1995 c.3 §5.01]
127.897 §6.01. Form of the request.	*** Refer directly to statute for form of patient written request. ***
127.995 Penalties.	(1) It shall be a Class A felony for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument or any other evidence or document reflecting the principal's desires and interests, with the intent and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition and hydration which hastens the death of the principal. (2) Except as provided in subsection (1) of this section, it shall be a Class A misdemeanor for a person without authorization of the principal to willfully alter, forge, conceal or destroy an instrument, the reinstatement or revocation of an instrument, or any other evidence or document reflecting the principal's desires and interests with the intent or effect of affecting a health care decision. [Formerly 127.585]

Vermont

Definitions.	As used in this chapter: (1) “Bona fide physician-patient relationship” means a treating or consulting relationship in the course of which a physician has completed a full assessment of the patient’s medical history and current medical condition, including a personal physical examination. (2) “Capable” means that a patient has the ability to make and communicate health care decisions to a physician, including communication through persons familiar with the patient’s manner of communicating if those persons are available. (3) “Health care facility” shall have the same meaning as in section 9432 of this title. (4) “Health care provider” means a person, partnership, corporation, facility, or institution licensed or certified or authorized by law to administer health care or dispense medication in the ordinary course of business or practice of a profession. (5) “Impaired judgment” means that a person does not sufficiently understand or appreciate the relevant facts necessary to make an informed decision. (6) “Interested person” means: (A) the patient’s physician; (B) a person who knows that he or she is a relative of the patient by blood, civil marriage, civil union, or adoption; (C) a person who knows that he or she would be entitled upon the patient’s death to any portion of the estate or assets of the patient under any will or trust, by operation of law, or by contract; or (D) an owner, operator, or employee of a health care facility, nursing home, or residential care facility where the patient is receiving medical treatment or is a resident. (7) “Palliative care” shall have the same definition as in section 2 of this title. (8) “Patient” means a person who is 18 years of age or older and under the care of a physician. (9) “Physician” means an individual licensed to practice medicine under 26 V.S.A. chapter 23 or 33. (10) “Terminal condition” means an incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months. (11) “Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. (12) “Telemedicine” means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. (Added 2013, No. 39, § 1, eff. May 20, 2013; amended 2021, No. 97 (Adj. Sess.), § 1, eff. April 27, 2022; 2023, No. 10, § 1, eff. May 2, 2023.)
Right to Information.	The rights of a patient under section 1871 of this title to be informed of all available options related to terminal care and under 12 V.S.A. § 1909(d) to receive answers to any specific question about the foreseeable risks and benefits of medication without the physician’s withholding any requested information exist regardless of the purpose of the inquiry or the nature of the information. A physician who engages in discussions with a patient related to such risks and benefits

in the circumstances described in this chapter shall not be construed to be assisting in or contributing to a patient's independent decision to self-administer a lethal dose of medication, and such discussions shall not be used to establish civil or criminal liability or professional disciplinary action. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

Requirements for Prescription and Documentation; Immunity.

(a) A physician shall not be subject to any civil or criminal liability or professional disciplinary action if the physician prescribes to a patient with a terminal condition medication to be self-administered for the purpose of hastening the patient's death and the physician affirms by documenting in the patient's medical record that all of the following occurred:

(1) The patient made an oral request to the physician in the physician's physical presence or by telemedicine, if the physician determines the use of telemedicine to be clinically appropriate, for medication to be self- administered for the purpose of hastening the patient's death.

(2) Not fewer than 15 days after the first oral request, the patient made a second oral request to the physician in the physician's physical presence or by telemedicine, if the physician determines the use of telemedicine to be clinically appropriate, for medication to be self-administered for the purpose of hastening the patient's death.

(3) At the time of the second oral request, the physician offered the patient an opportunity to rescind the request.

(4) The patient made a written request for medication to be self-administered for the purpose of hastening the patient's death that was signed by the patient in the presence of two or more witnesses who were not interested persons, who were at least 18 years of age, and who signed and affirmed that the patient appeared to understand the nature of the document and to be free from duress or undue influence at the time the request was signed.

(5) The physician determined that the patient:

(A) was suffering a terminal condition, based on the physician's review of the patient's relevant medical records and a physician's physical examination of the patient;

(B) was capable;

(C) was making an informed decision; and

(D) had made a voluntary request for medication to hasten the patient's own death.

(6) The physician informed the patient in person or by telemedicine, both verbally and in writing, of all the following:

(A) the patient's medical diagnosis;

(B) the patient's prognosis, including an acknowledgement that the physician's prediction of the patient's life expectancy was an estimate based on the physician's best medical judgment and was not a guarantee of the actual time remaining in the patient's life, and that the patient could live longer than the time predicted;

(C) the range of treatment options appropriate for the patient and the patient's diagnosis;

(D) if the patient was not enrolled in hospice care, all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control;

(E) the range of possible results, including potential risks associated with taking the medication to be prescribed; and

(F) the probable result of taking the medication to be prescribed.

(7) The physician referred the patient to a second physician for medical confirmation of the diagnosis, prognosis,

and a determination that the patient was capable, was acting voluntarily, and had made an informed decision.

(8) The physician either verified that the patient did not have impaired judgment or referred the patient for an evaluation by a psychiatrist, psychologist, or clinical social worker licensed in Vermont for confirmation that the patient was capable and did not have impaired judgment.

(9) If applicable, the physician consulted with the patient's primary care physician with the patient's consent.

(10) The physician informed the patient that the patient may rescind the request at any time and in any manner and offered the patient an opportunity to rescind after the patient's second oral request.

(11) The physician ensured that all required steps were carried out in accordance with this section and confirmed, immediately prior to writing the prescription for medication, that the patient was making an informed decision.

(12) The physician wrote the prescription after the last to occur of the following events:

(A) the patient's written request for medication to hasten the patient's own death;

(B) the patient's second oral request; and

(C) the physician's offering the patient an opportunity to rescind the request.

(13) The physician either:

(A) dispensed the medication directly, provided that at the time the physician dispensed the medication, the physician was licensed to dispense medication in Vermont, had a current Drug Enforcement Administration certificate, and complied with any applicable administrative rules; or

(B) with the patient's written consent:

(i) contacted a pharmacist and informed the pharmacist of the prescription; and

(ii) delivered the written prescription personally or by mail or facsimile to the pharmacist, who dispensed the medication to the patient, the physician, or an expressly identified agent of the patient.

(14) The physician recorded and filed the following in the patient's medical record:

(A) the date, time, and wording of all oral requests of the patient for medication to hasten the patient's own death;

(B) all written requests by the patient for medication to hasten the patient's own death;

(C) the physician's diagnosis, prognosis, and basis for the determination that the patient was capable, was acting voluntarily, and had made an informed decision;

(D) the second physician's diagnosis, prognosis, and verification that the patient was capable, was acting voluntarily, and had made an informed decision;

(E) the physician's attestation that the patient was enrolled in hospice care at the time of the patient's oral and written requests for medication to hasten the patient's own death or that the physician informed the patient of all feasible end-of-life services;

(F) the physician's verification that the patient either did not have impaired judgment or that the physician referred the patient for an evaluation and the person conducting the evaluation has determined that the patient did not have impaired judgment;

(G) a report of the outcome and determinations made during any evaluation which the patient may have received;

(H) the date, time, and wording of the physician's offer to the patient to rescind the request for medication at the

time of the patient's second oral request; and

(I) a note by the physician indicating that all requirements under this section were satisfied and describing all of the steps taken to carry out the request, including a notation of the medication prescribed.

(15) After writing the prescription, the physician promptly filed a report with the Department of Health documenting completion of all of the requirements under this section.

(b) This section shall not be construed to limit civil or criminal liability for gross negligence, recklessness, or intentional misconduct. (Added 2013, No. 39, § 1, eff. May 20, 2013; amended 2021, No. 97 (Adj. Sess.), § 2, eff. April 27, 2022; 2023, No. 10, § 2, eff. May 2, 2023.)

No Duty to Aid.

A patient with a terminal condition who self-administers a lethal dose of medication shall not be considered to be a person exposed to grave physical harm under 12 V.S.A. § 519, and no person shall be subject to civil or criminal liability solely for being present when a patient with a terminal condition self-administers a lethal dose of medication or for not acting to prevent the patient from self-administering a lethal dose of medication. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

Limitations on Actions.

(a) A physician, nurse, pharmacist, or other person shall not be under any duty, by law or contract, to participate in the provision of a lethal dose of medication to a patient.

(b) A health care facility or health care provider shall not subject a physician, nurse, pharmacist, or other person to discipline, suspension, loss of license, loss of privileges, or other penalty for actions taken in good faith reliance on the provisions of this chapter or refusals to act under this chapter.

(c) No physician, nurse, pharmacist, or other person licensed, certified, or otherwise authorized by law to deliver health care services in this State shall be subject to civil or criminal liability or professional disciplinary action for acting in good faith compliance with the provisions of this chapter.

(d) Except as otherwise provided in this section and sections 5283, 5289, and 5290 of this title, nothing in this chapter shall be construed to limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person. (Added 2013, No. 39, § 1, eff. May 20, 2013; amended 2021, No. 97 (Adj. Sess.), § 3, eff. April 27, 2022.)

Health Care Facility Exception.

A health care facility may prohibit a physician from writing a prescription for a dose of medication intended to be lethal for a patient who is a resident in its facility and intends to use the medication on the facility's premises, provided the facility has notified the physician in writing of its policy with regard to the prescriptions. Notwithstanding subsection 5285(b) of this title, any physician who violates a policy established by a health care facility under this section may be subject to sanctions otherwise allowable under law or contract. (Added 2013, No. 39, § 1, eff. May 20, 2013.)

Insurance Policies; Prohibitions.

(a) A person and his or her beneficiaries shall not be denied benefits under a life insurance policy, as defined in 8 V.S.A. § 3301, for actions taken in accordance with this chapter.

	(b) The sale, procurement, or issue of any medical malpractice insurance policy or the rate charged for the policy shall not be conditioned upon or affected by whether the physician is willing or unwilling to participate in the provisions of this chapter. (Added 2013, No. 39, § 1, eff. May 20, 2013.)
No Effect on Palliative Sedation.	This chapter shall not limit or otherwise affect the provision, administration, or receipt of palliative sedation consistent with accepted medical standards. (Added 2013, No. 39, § 1, eff. May 20, 2013.)
Sunset.	§§ 5289, 5290. Repealed. 2015, No. 27, § 1, effective May 20, 2015.
Safe Disposal of Unused Medications.	The Department of Health shall adopt rules providing for the safe disposal of unused medications prescribed under this chapter. (Added 2013, No. 39, § 1, eff. May 20, 2013.)
Statutory Construction.	Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Action taken in accordance with this chapter shall not be construed for any purpose to constitute suicide, assisted suicide, mercy killing, or homicide under the law. This section shall not be construed to conflict with section 1553 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152. (Added 2013, No. 39, § 1, eff. May 20, 2013.)
Reporting Requirements.	(a) The Department of Health shall adopt rules pursuant to 3 V.S.A. chapter 25 to facilitate the collection of information regarding compliance with this chapter, including identifying patients who filled prescriptions written pursuant to this chapter. Except as otherwise required by law, information regarding compliance shall be confidential and shall be exempt from public inspection and copying under the Public Records Act. (b) Beginning in 2018, the Department of Health shall generate and make available to the public a biennial statistical report of the information collected pursuant to subsection (a) of this section, as long as releasing the information complies with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191. (Added 2015, No. 27, § 2, eff. May 20, 2015.)

Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.
(1) "Adult" means an individual who is 18 years of age or older.
(2) "Attending qualified medical provider" means the qualified medical provider who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
(3) "Competent" means that, in the opinion of a court or in the opinion of the patient's attending qualified medical provider, consulting qualified medical provider, psychiatrist, or psychologist, a patient has the ability to make and communicate an informed decision to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
(4) "Consulting qualified medical provider" means a qualified medical provider who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
(5) "Counseling" means one or more consultations as necessary between a state licensed psychiatrist, psychologist, independent clinical social worker, advanced social worker, mental health counselor, or psychiatric advanced registered nurse practitioner and a patient for the purpose of determining that the patient is competent and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
(6) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by law to administer health care or dispense medication in the ordinary course of business or practice of a profession, and includes a health care facility.
(7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending qualified medical provider of:
    (a) His or her medical diagnosis;
    (b) His or her prognosis;
    (c) The potential risks associated with taking the medication to be prescribed;
    (d) The probable result of taking the medication to be prescribed; and
    (e) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control.
(8) "Medically confirmed" means the medical opinion of the attending qualified medical provider has been confirmed by a consulting qualified medical provider who has examined the patient and the patient's relevant medical records.
(9) "Patient" means a person who is under the care of an attending qualified medical provider.
(10) "Qualified medical provider" means a physician licensed under chapter 18.57 or 18.71 RCW, a physician assistant licensed under chapter 18.71A RCW, or an advanced registered nurse practitioner licensed under chapter 18.79 RCW.
(11) "Qualified patient" means a competent adult who is a resident of Washington state and has satisfied the requirements of this chapter in order to obtain a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner.
(12) "Self-administer" means a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner.
(13) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within

reasonable medical judgment, produce death within six months.
[2023 c 38 § 1; 2009 c 1 § 1 (Initiative Measure No. 1000, approved November 4, 2008).]

Written Request for Medication.

(1) An adult patient who is competent, is a resident of Washington state, and has been determined by the attending qualified medical provider to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication that the patient may self-administer to end the patient's life in a humane and dignified manner in accordance with this chapter.
(2) A person does not qualify under this chapter solely because of age or disability.
[2023 c 38 § 3; 2009 c 1 § 2 (Initiative Measure No. 1000, approved November 4, 2008).]

Form of the Written Request.

(1) A valid request for medication under this chapter shall be in substantially the form described in RCW 70.245.220, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is competent, acting voluntarily, and is not being coerced to sign the request.
(2) One of the witnesses shall be a person who is not:
(a) A relative of the patient by blood or by law;
(b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
(c) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
(3) The patient's attending qualified medical provider at the time the request is signed shall not be a witness.
[2023 c 38 § 4; 2009 c 1 § 3 (Initiative Measure No. 1000, approved November 4, 2008).]

Attending Qualified Medical Provider Responsibilities.

(1) The attending qualified medical provider shall:
(a) Make the determination of whether a patient has a terminal disease, is competent, and has made the request voluntarily;
(b) Request that the patient demonstrate Washington state residency under RCW 70.245.130;
(c) To ensure that the patient is making an informed decision, inform the patient of:
(i) The patient's medical diagnosis;
(ii) The patient's prognosis;
(iii) The potential risks associated with taking the medication to be prescribed;
(iv) The probable result of taking the medication to be prescribed; and
(v) The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control;
(d) Refer the patient to a consulting qualified medical provider for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily;
(e) Refer the patient for counseling if appropriate under RCW 70.245.060;

(f) Recommend that the patient notify next of kin;

(g) Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this chapter and of not taking the medication in a public place;

(h) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the relevant waiting period under RCW 70.245.090;

(i) Verify, immediately before writing the prescription for medication under this chapter, that the patient is making an informed decision;

(j) Fulfill the medical record documentation requirements of RCW 70.245.120;

(k) Ensure that all appropriate steps are carried out in accordance with this chapter before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

(l)(i) Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending qualified medical provider is authorized under statute and rule to dispense and has a current drug enforcement administration certificate; or

(ii)(A) Contact a pharmacist and inform the pharmacist of the prescription; and

(B) Deliver the written prescription personally, by mail, facsimile, or electronically to the pharmacist, who will dispense the medications directly to either the patient, the attending qualified medical provider, or another person as requested by the qualified patient.

(2) The attending qualified medical provider may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death.

(3) Delivery of the dispensed drug to the qualified patient, the attending qualified medical provider, or another person as requested by the qualified patient may be made only:

(a) By personal delivery, messenger service, or the United States postal service or a similar private parcel delivery entity; and

(b) Upon the receipt of the signature of the addressee or an authorized person at the time of delivery by an entity listed in (a) of this subsection.

[2023 c 38 § 5; 2009 c 1 § 4 (Initiative Measure No. 1000, approved November 4, 2008).]

Consulting Qualified Medical Provider Confirmation.

Before a patient is qualified under this chapter, a consulting qualified medical provider shall examine the patient and his or her relevant medical records and confirm, in writing, the attending qualified medical provider's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is competent, is acting voluntarily, and has made an informed decision.

[2023 c 38 § 6; 2009 c 1 § 5 (Initiative Measure No. 1000, approved November 4, 2008).]

Counseling Referral.

If, in the opinion of either the attending qualified medical provider or the consulting qualified medical provider, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, the qualified medical provider shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified

	manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment. [2023 c 38 § 7; 2009 c 1 § 6 (Initiative Measure No. 1000, approved November 4, 2008).]
Informed Decision.	A person shall not receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision. Immediately before writing a prescription for medication under this chapter, the attending qualified medical provider shall verify that the qualified patient is making an informed decision. [2023 c 38 § 8; 2009 c 1 § 7 (Initiative Measure No. 1000, approved November 4, 2008).]
Notification of Next of Kin.	The attending qualified medical provider shall recommend that the patient notify the next of kin of his or her request for medication under this chapter. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason. [2023 c 38 § 9; 2009 c 1 § 8 (Initiative Measure No. 1000, approved November 4, 2008).]
Written and Oral Requests.	(1) To receive a prescription for medication that the qualified patient may self-administer to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending qualified medical provider at least seven days after making the initial oral request. (2) At the time the qualified patient makes his or her second oral request, the attending qualified medical provider shall offer the qualified patient an opportunity to rescind the request. (3) A transfer of care or medical records does not restart any waiting period under this section. [2023 c 38 § 10; 2009 c 1 § 9 (Initiative Measure No. 1000, approved November 4, 2008).]
Right to Rescind Request.	A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this chapter may be written without the attending qualified medical provider offering the qualified patient an opportunity to rescind the request. [2023 c 38 § 11; 2009 c 1 § 10 (Initiative Measure No. 1000, approved November 4, 2008).]
Waiting Periods.	At least seven days shall elapse between the patient's initial oral request and the writing of a prescription under this chapter. [2023 c 38 § 12; 2009 c 1 § 11 (Initiative Measure No. 1000, approved November 4, 2008).]
Medical Record Documentation Requirements.	The following shall be documented or filed in the patient's medical record: (1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner; (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending qualified medical provider's diagnosis and prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;
(4) The consulting qualified medical provider's diagnosis and prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;
(5) A report of the outcome and determinations made during counseling, if performed;
(6) The attending qualified medical provider's offer to the patient to rescind his or her request at the time of the patient's second oral request under RCW 70.245.090; and
(7) A note by the attending qualified medical provider indicating that all requirements under this chapter have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.
[2023 c 38 § 13; 2009 c 1 § 12 (Initiative Measure No. 1000, approved November 4, 2008).]

Residency Requirement.	Only requests made by Washington state residents under this chapter may be granted. Factors demonstrating Washington state residency include but are not limited to: (1) Possession of a Washington state driver's license; (2) Registration to vote in Washington state; or (3) Evidence that the person owns or leases property in Washington state. [2009 c 1 § 13 (Initiative Measure No. 1000, approved November 4, 2008).]
Disposal of Unused Medications.	Any medication dispensed under this chapter that was not self-administered shall be disposed of by lawful means. [2009 c 1 § 14 (Initiative Measure No. 1000, approved November 4, 2008).]
Reporting of Information to the Department of Health—Adoption of Rules—Information Collected not a Public Record—Annual Statistical Report.	(1)(a) The department of health shall annually review all records maintained under this chapter. (b) The department of health shall require any health care provider upon writing a prescription or dispensing medication under this chapter to file a copy of the dispensing record and such other administratively required documentation with the department. All administratively required documentation shall be transmitted electronically, mailed, or otherwise transmitted as allowed by department of health rule to the department no later than 30 calendar days after the writing of a prescription and dispensing of medication under this chapter, except that all documents required to be filed with the department by the prescribing qualified medical provider after the death of the patient shall be transmitted electronically, mailed, or faxed no later than 30 calendar days after the date of death of the patient. In the event that anyone required under this chapter to report information to the department of health provides an inadequate or incomplete report, the department shall contact the person to request a complete report. (2) The department of health shall adopt rules to facilitate the collection of information regarding compliance with this chapter. Except as otherwise required by law, the information collected is not a public record and may not be made available for inspection by the public. (3) The department of health shall generate and make available to the public an annual statistical report of information collected under subsection (2) of this section.

[2023 c 38 § 14; 2009 c 1 § 15 (Initiative Measure No. 1000, approved November 4, 2008).]

Effect on Construction of Wills, Contracts, and Statutes.	(1) Any provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, is not valid. (2) Any obligation owing under any currently existing contract shall not be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. [2009 c 1 § 16 (Initiative Measure No. 1000, approved November 4, 2008).]
Insurance or Annuity Policies.	The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication that the patient may self-administer to end his or her life in a humane and dignified manner. A qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner shall not have an effect upon a life, health, or accident insurance or annuity policy. [2009 c 1 § 17 (Initiative Measure No. 1000, approved November 4, 2008).]
Authority of Chapter—References to Practices Under this Chapter—Applicable Standard of Care.	(1) Nothing in this chapter authorizes an attending qualified medical provider, consulting qualified medical provider, or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, mercy killing, or homicide, under the law. State reports shall not refer to practice under this chapter as "suicide" or "assisted suicide." Consistent with RCW 70.245.010 (7), (11), and (12), 70.245.020(1), 70.245.040(1)(k), 70.245.060, 70.245.070, 70.245.090, 70.245.120 (1) and (2), 70.245.160 (1) and (2), 70.245.170, 70.245.190(1) (a) and (d), and 70.245.200(2), state reports shall refer to practice under this chapter as obtaining and self-administering life-ending medication. (2) Nothing contained in this chapter shall be interpreted to lower the applicable standard of care for the attending qualified medical provider, consulting qualified medical provider, psychiatrist or psychologist, or other health care provider participating under this chapter. [2023 c 38 § 15; 2009 c 1 § 18 (Initiative Measure No. 1000, approved November 4, 2008).]
Immunities—Basis For Prohibiting Health Care Provider From Participation—Notification—Permissible Sanctions.	(1) Except as provided in RCW 70.245.200 and subsection (2) of this section: (a) A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this chapter. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner; (b) A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating or refusing to participate in good faith compliance with this chapter;

(c) A patient's request for or provision by an attending qualified medical provider of medication in good faith compliance with this chapter does not constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator; and

(d) Only willing health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this chapter, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(2)(a) A health care provider may prohibit another health care provider from participating under chapter 1, Laws of 2009 on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under chapter 1, Laws of 2009. A health care provider may not, by contract or other form of agreement, prohibit another health care provider from participating under chapter 1, Laws of 2009 while acting outside the course and scope of the provider's capacity as an employee or independent contractor of the prohibiting health care provider and while at a location that is not on the prohibiting health care provider's premises and not on property that is owned by, leased by, or under the direct control of the prohibiting health care provider. This subsection does not prevent a health care provider from providing health care services to a patient that do not constitute participation under chapter 1, Laws of 2009.

(b) A health care provider may subject another health care provider to the sanctions stated in this subsection if the sanctioning health care provider has notified the sanctioned provider before participation in chapter 1, Laws of 2009 that it prohibits participation in chapter 1, Laws of 2009:

(i) Loss of privileges, loss of membership, or other sanctions provided under the medical staff bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member of the sanctioning provider's medical staff and participates in chapter 1, Laws of 2009 while on the health care facility premises of the sanctioning health care provider, but not including the private medical office of a qualified medical provider or other provider;

(ii) Termination of a lease or other property contract or other nonmonetary remedies provided by a lease contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the sanctioned provider participates in chapter 1, Laws of 2009 while on the premises of the sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning health care provider; or

(iii) Termination of a contract or other nonmonetary remedies provided by contract if the sanctioned provider participates in chapter 1, Laws of 2009 while acting in the course and scope of the sanctioned provider's capacity as an employee or independent contractor of the sanctioning health care provider. Nothing in this subsection (2)(b)(iii) prevents:

(A) A health care provider from participating in chapter 1, Laws of 2009 while acting outside the course and scope of the provider's capacity as an employee or independent contractor and while at a location that is not on the sanctioning health care provider's facility premises and is not on property that is owned by, leased by, or under the direct control of the sanctioning health care provider; or

(B) A patient from contracting with his or her attending qualified medical provider and consulting qualified

medical provider to act outside the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider and while at a location that is not on the sanctioning health care provider's facility premises and is not on property that is owned by, leased by, or under the direct control of the sanctioning health care provider.

(c) A health care provider that imposes sanctions under (b) of this subsection shall follow all due process and other procedures the sanctioning health care provider may have that are related to the imposition of sanctions on another health care provider.

(d) For the purposes of this subsection:

(i) "Notify" means a separate statement in writing to the health care provider specifically informing the health care provider before the provider's participation in chapter 1, Laws of 2009 of the sanctioning health care provider's policy about participation in activities covered by this chapter.

(ii) "Participate in chapter 1, Laws of 2009" means to perform the duties of an attending qualified medical provider under RCW 70.245.040, the consulting qualified medical provider function under RCW 70.245.050, or the counseling function under RCW 70.245.060. "Participate in chapter 1, Laws of 2009" does not include:

(A) Making an initial determination that a patient has a terminal disease and informing the patient of the medical prognosis;

(B) Providing information about the Washington death with dignity act to a patient upon the request of the patient;

(C) Charting a patient's first request, as referenced in RCW 70.245.020, to services as provided in chapter 1, Laws of 2009;

(D) Providing a patient, upon the request of the patient, with a referral to another attending or consulting qualified medical provider; or

(E) A patient contracting with his or her attending qualified medical provider and consulting qualified medical provider to act outside of the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning health care provider.

(3) Suspension or termination of staff membership or privileges under subsection (2) of this section is not reportable under RCW 18.130.070. Action taken under RCW 70.245.030, 70.245.040, 70.245.050, or 70.245.060 may not be the sole basis for a report of unprofessional conduct under RCW 18.130.180.

(4) References to "good faith" in subsection (1)(a), (b), and (c) of this section do not allow a lower standard of care for health care providers in the state of Washington.

[2023 c 38 § 16; 2009 c 1 § 19 (Initiative Measure No. 1000, approved November 4, 2008).]

Willful Alteration/Forgery—Coercion or Undue Influence—Penalties—	(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death is guilty of a class A felony. (2) A person who coerces or exerts undue influence on a patient to request medication to end the patient's life, or to destroy a rescission of a request, is guilty of a class A felony.

Washington

Civil Damages—Other Penalties not Precluded.	(3) This chapter does not limit further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person. (4) The penalties in this chapter do not preclude criminal penalties applicable under other law for conduct that is inconsistent with this chapter. [2009 c 1 § 20 (Initiative Measure No. 1000, approved November 4, 2008).]
Claims by Governmental Entity for Costs Incurred.	Any governmental entity that incurs costs resulting from a person terminating his or her life under this chapter in a public place has a claim against the estate of the person to recover such costs and reasonable attorneys' fees related to enforcing the claim. [2009 c 1 § 21 (Initiative Measure No. 1000, approved November 4, 2008).]
Selection of Qualified Medical Provider.	(1) Subject to the provisions in subsection (2) of this section, a qualified patient may select the attending or consulting qualified medical provider of the qualified patient's choosing. (2)(a) If a qualified patient selects an attending qualified medical provider who is a licensed professional other than a physician, the qualified patient must select a physician to serve as the qualified patient's consulting qualified medical provider. (b) A qualified patient may select a consulting qualified medical provider who is a licensed professional other than a physician, only if the qualified patient's attending qualified medical provider is a physician. (c) The attending qualified medical provider and the consulting qualified medical provider selected by the qualified patient may not have a direct supervisory relationship with each other. [2023 c 38 § 2.]
Form of the Request.	*** Refer directly to statute for form of patient written request. ***
Short Title.	This act may be known and cited as the Washington death with dignity act. [2009 c 1 § 26 (Initiative Measure No. 1000, approved November 4, 2008).]

Definitions.

For the purposes of this chapter, the term:
(1) "Attending physician" shall have the same meaning as provided in § 7-621(1); provided, that the attending physician's practice shall not be primarily or solely composed of patients requesting a covered medication.
(2) "Capable" means that, in the opinion of a court or the patient's attending physician, consulting physician, psychiatrist, or psychologist, a patient has the ability to make and communicate health care decisions to health care providers.
(3) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease and who is willing to participate in the provision of a covered medication to a qualified patient in accordance with this chapter.
(4) "Counseling" means one or more consultations as necessary between a District licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
(5) "Covered medication" means a medication prescribed pursuant to this chapter for the purpose of ending a person's life in a humane and peaceful manner.
(6) "Department" means the Department of Health.
(7) "Health care facility" means a hospital or long-term care facility.
(8) "Health care provider" means a person, partnership, corporation, facility, or institution that is licensed, certified, or authorized under District law to administer health care or dispense medication in the ordinary course of business or practice of a profession.
(9) "Hospital" shall have the same meaning as provided in § 44-501(a)(1).
(10) "Informed decision" means a decision by a qualified patient to request and obtain a prescription for a covered medication that is based on an appreciation of the relevant facts and is made after being fully informed by the attending physician of:
    (A) His or her medical diagnosis;
    (B) His or her prognosis;
    (C) The potential risks associated with taking the covered medication;
    (D) The probable results of taking the covered medication; and
    (E) Feasible alternatives to taking the covered medication, including comfort care, hospice care, and pain control.
(11) "Long-term care facility" means a nursing home or community residence facility, as defined by § 44-501(a)(3) and (4), or an assisted living residence, as defined by § 44-102.01(4).
(12) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
(13) "Patient" means a person who has attained 18 years of age, resides in the District of Columbia, and is under the care of a physician.
(14) "Physician" shall have the same meaning as provided in § 7-621(4).
(15) "Qualified patient" means a patient who:
    (A) Has been determined to be capable; and

(B) Satisfies the requirements of this chapter in order to obtain a prescription for a covered medication.

(16) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within 6 months.

(Feb. 18, 2017, D.C. Law 21-182, § 2, 63 DCR 15697.)

Requests for a Covered Medication.

(a) To request a covered medication, a patient shall:

(1) Make 2 oral requests, separated by at least 15 days, to an attending physician.

(2) Submit a written request, signed and dated by the patient, to the attending physician before the patient makes his or her 2nd oral request and at least 48 hours before a covered medication may be prescribed or dispensed.

(b)(1) A written request made pursuant to subsection (a)(2) of this section shall be witnessed by at least 2 individuals who, in the presence of the patient, attest to the best of their knowledge and belief that the patient is capable, acting voluntarily, and is not being unduly influenced to sign the request.

(2) If the patient is a patient in a long-term care facility at the time the written request is made under subsection (a)(2) of this section, one of the witnesses shall be an individual designated by the facility who has met the qualifications specified in the Department's regulations.

(3) One of the witnesses shall be a person who is not:

(A) A relative of the patient by blood, marriage, or adoption;

(B) At the time the request is signed, entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or

(C) An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(4) The patient's attending physician at the time of the request shall not be a witness.

(c) A written request made pursuant to subsection (a)(2) of this section shall be in substantially the following form:

*** Refer directly to statute for form of patient written request. ***

(Feb. 18, 2017, D.C. Law 21-182, § 3, 63 DCR 15697.)

Responsibilities of the Attending Physician.

(a) Upon receiving a written request for a covered medication pursuant to § 7-661.02(a)(2), the attending physician shall:

(1) Determine that the patient:

(A) Has a terminal disease;

(B) Is capable;

(C) Has made the request voluntarily; and

(D) Is a resident of the District of Columbia;

(2) Inform the patient of:

(A) His or her medical diagnosis;

(B) His or her prognosis;

(C) The potential risks associated with taking a covered medication;

(D) The probable result of taking a covered medication; and
(E) The feasible alternatives to taking a covered medication, including comfort care, hospice care, and pain control;
(3) Refer the patient to a consulting physician;
(4) Refer the patient to counseling if appropriate, pursuant to § 7-661.04;
(5) Inform the patient of the availability of supportive counseling to address the range of possible psychological and emotional stress involved with the end stages of life;
(6) Recommend that the patient notify next of kin, friends, and spiritual advisor, if applicable, of his or her decision to request a covered medication;
(7) Counsel the patient about the importance of having another person present when the patient takes a covered medication and of not taking a covered medication in a public place;
(8) Inform the patient that he or she has an opportunity to rescind a request for a covered medication at any time and in any manner;
(9) Verify, immediately before writing the prescription for a covered medication, that the patient is making an informed decision; and
(10) Fulfill the medical record documentation requirements of § 7-661.06.
(b) If a consulting physician receives a referral for a patient from an attending physician pursuant to subsection (a)(3) of this section, the consulting physician shall:
(1) Examine the patient and his or her relevant medical records to confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease;
(2) Verify, in writing, to the attending physician that the patient:
(A) Is capable;
(B) Is acting voluntarily; and
(C) Has made an informed decision; and
(3) Refer the patient to counseling if appropriate, pursuant to § 7-661.04.
(Feb. 18, 2017, D.C. Law 21-182, § 4, 63 DCR 15697.)

Counseling Referral.

(a) If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient to counseling.
(b) No covered medication shall be prescribed until the patient receives counseling and the psychiatrist or psychologist performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
(Feb. 18, 2017, D.C. Law 21-182, § 5, 63 DCR 15697.)

Dispensing a Covered Medication and

(a) An attending physician may not prescribe or dispense a covered medication, unless:
(1) The patient has satisfied the requirements of §§ 7-661.02 and 7-661.04, if applicable;

Reporting Requirements.

(2) The attending physician has satisfied the requirements of §§ 7-661.03 and 7-661.04, if applicable; and

(3) The attending physician has offered the patient an opportunity to rescind his or her request for a covered medication immediately before prescribing or dispensing the covered medication.

(b) After the attending physician ensures that the requirements provided in subsection (a) of this section have been met, the attending physician may:

(1) Dispense a covered medication, including ancillary medications intended to minimize the patient's discomfort, directly to the qualified patient; provided, that the attending physician is authorized to do so in § 48-903.02 and has a current Drug Enforcement Administration certificate issued pursuant to 21 C.F.R. § 1301.35; or

(2) After a qualified patient completes the form under § 7-661.02(c):

(A) Contact a pharmacist and inform the pharmacist of the prescription for a covered medication; and

(B) Deliver the written prescription for a covered medication personally, or by telephone, facsimile, or electronically to the pharmacist.

(c) Upon receiving a written prescription for a covered medication by an attending physician under subsection (b)(2) of this section, the pharmacist may dispense the covered medication to the following:

(A) The patient;

(B) The attending physician; or

(C) An expressly identified agent designated by the qualified patient, with the designation communicated to the pharmacist by the patient verbally or in writing.

(d) A pharmacist, upon dispensing a covered medication under subsection (c) of this section, shall immediately notify the attending physician that the covered medication was dispensed.

(e) Within 30 days after a health care provider dispenses a covered medication, the attending physician shall file with the Department a copy of the information required by § 7-661.06 on a form created by the Department.

(f) Within 30 days after a patient ingests a covered medication, or as soon as practicable after the a health care provider is made aware of a patient's death resulting from ingesting the covered medication, the health care provider shall notify the Department of a patient's death.

(g) Notwithstanding any other provision of law, the attending physician may sign the patient's death certificate.

(h) The cause of death listed on a death certificate shall identify the qualified patient's underlying medical condition consistent with the International Classification of Diseases without reference to the fact that the qualified patient ingested a covered medication.

(i)(1) The Office of the Chief Medical Examiner shall review each death involving a qualified patient who ingests a covered medication and, if warranted by the review, may conduct an investigation.

(2) The review required by paragraph (1) of this subsection shall not constitute an inquiry for the purposes of § 7-211; provided, that an investigation authorized by paragraph (1) of this subsection shall constitute an inquiry for the purposes of Chapter 2 of this title.

(Feb. 18, 2017, D.C. Law 21-182, § 6, 63 DCR 15697.)

Medical Record Documentation Requirements.

(a) The attending physician shall document and file in the medical record of the patient requesting a covered medication:
(1) All oral requests by a patient for a covered medication;
(2) All written requests by a patient for a covered medication;
(3) The attending physician's:
(A) Diagnosis and prognosis of the patient;
(B) Determination that the patient is a District resident and is capable, acting voluntarily, and has made an informed decision when requesting a covered medication;
(C) Offer to the patient to rescind his or her request for a covered medication before the patient makes his or her second oral request;
(D) Notation that all requirements under this chapter have been met; and
(E) Notation regarding all steps taken to carry out the patient's request for a covered medication, including a notation of the covered medication prescribed;
(4) The consulting physician's:
(A) Diagnosis and prognosis of the patient;
(B) Verification that the patient is capable, acting voluntarily, and has made an informed decision when requesting a covered medication; and
(5) If a patient is referred to counseling pursuant to § 7-661.04, a report by the psychiatrist or psychologist of the outcome and determinations made during counseling.
(Feb. 18, 2017, D.C. Law 21-182, § 7, 63 DCR 15697.)

Reporting Requirements.

(a) Beginning one year after February 18, 2017, and on an annual basis thereafter, the Department shall review the records maintained under § 7-661.06 for the purpose of gathering data and ensuring compliance with this chapter.
(b) The Department shall generate and make available to the public an annual statistical report of information collected pursuant to subsection (a) of this section. The report shall include:
(1) The number of qualified patients for whom a prescription for a covered medication was written;
(2) The number of known qualified patients who died each year for whom a prescription for a covered medication was written, and the cause of death of those patients;
(3) The number of known deaths in the District from using a covered medication;
(4) The number of physicians who wrote prescriptions for a covered medication; and
(5) Of the qualified patients who died due to using a covered medication, demographic percentages organized by the following characteristics:
(A) Age at death;
(B) Education level, if known;
(C) Race;
(D) Sex;
(E) Type of insurance, including whether or not they had insurance, if known; and

(F) Terminal disease.
(Feb. 18, 2017, D.C. Law 21-182, § 8, 63 DCR 15697.)

Effect on Construction of Wills and Contracts.

(a) A provision in a contract, will, or other agreement executed on or after February 18, 2017, whether written or oral, is not valid if the provision would affect whether a person may make or rescind a request for a covered medication.
(b) An obligation owing under any contract, will, or other agreement executed on or after February 18, 2017 may not be conditioned or affected by a person making or rescinding a request for a covered medication.
(Feb. 18, 2017, D.C. Law 21-182, § 9, 63 DCR 15697.)

Insurance and Annuity Policies.

(a) The sale, procurement, or issuance of any life, health, accident insurance, annuity policy, employment benefits, or the rate charged for any policy may not be conditioned upon or affected by the making or rescinding of a qualified patient's request for a covered medication.
(b) A qualified patient's act of ingesting a covered medication shall not have an effect upon a life, health, accident insurance, annuity policy, or employment benefits.
(c) Nothing in this section shall be construed to limit the ability of an insurance or annuity provider from investigating a claim for benefits for a death.
(Feb. 18, 2017, D.C. Law 21-182, § 10, 63 DCR 15697.)

Health Care Provider Participation; Notification; Permissible Sanctions.

(a) No health care provider shall be obligated under this chapter, by contract, or otherwise, to participate in the provision of a covered medication to a qualified patient.
(b) If a health care provider is unable or unwilling to carry out a patient's request for a covered medication under this chapter and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request of the patient, a copy of the patient's relevant medical records to the new health care provider.
(c) A health care provider may prohibit any other health care provider that it employs or contracts with from providing a covered medication under this chapter on the prohibiting health care provider's premises; provided, that the prohibiting health care provider has notified the health care provider of this policy before the employee or contractor has provided a covered medication.
(d) Notwithstanding § 7-661.11, if, before a covered medication has been provided, the prohibiting health care provider has notified the sanctioned health care provider that it prohibits providing a covered medication under this chapter, the prohibiting health care provider may impose the following sanctions:
(1) Loss of privileges, loss of membership, or other sanction pursuant to the prohibiting health care provider's medical staff bylaws, policies, and procedures, if the sanctioned health care provider is a member of the prohibiting health care provider's medical staff and participates under this chapter while on staff on the premises of the prohibiting health care provider's health care facility;
(2) Termination of the lease or other property contract or other nonmonetary remedies provided under the lease or property contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the

sanctioned health care provider participates under this chapter while on the premises of a prohibiting health care provider's health care facility or on the property that is owned by or under the direct control of the prohibiting health care provider;

(3) Termination of an employment contract or other nonmonetary remedies provided by contract if the sanctioned health care provider participates under this chapter in the course and scope of the sanctioned health care provider's duties as an employee or independent contractor of the prohibiting health care provider; or

(4) Any other sanctions and penalties in accordance with the prohibiting health care provider's policies and practices; provided, that no sanctions or penalties shall be imposed under this paragraph without a procedure for contesting the sections and penalties.

(e) Nothing in this section shall be construed to prevent:

(1) A health care provider from participating under this chapter while acting outside the course and scope of the health care provider's duties as an employee or independent contractor of the prohibiting health care provider;

(2) A patient from contracting with his or her attending physician and consulting physician to act outside the course and scope of the health care provider's duties as an employee or independent contractor of the prohibiting health care provider;

(3) A health care provider from making an initial determination pursuant to the standard of care that a patient has a terminal disease and informing him or her of the medical prognosis;

(4) A health care provider from providing information about this chapter upon the request of the patient; or

(5) A health care provider from providing a patient, upon request, with a referral to another health care provider.

(f) Sanctions issued pursuant to subsection (d) of this section are not reportable under § 3-1205.13(a)(4)(C).

(Feb. 18, 2017, D.C. Law 21-182, § 11, 63 DCR 15697.)

Immunities, Liabilities, and Exceptions.

(a) Except as provided in § 7-661.10, no person shall be subject to civil or criminal liability or professional disciplinary action for:

(1) Participating in good faith compliance with this chapter;

(2) Refusing to participate in providing a covered medication under this chapter; or

(3) Being present when a qualified patient takes a covered medication.

(b) Nothing in this chapter shall be interpreted to lower the applicable standard of care for the attending physician, consulting physician, psychiatrist, psychologist, or other health care provider participating in this chapter.

(c) No request by a patient for a covered medication made in good-faith compliance with the provisions of this chapter shall provide the basis for the appointment of a guardian or conservator.

(Feb. 18, 2017, D.C. Law 21-182, § 12, 63 DCR 15697.)

Claims by District Government for Costs Incurred.

If the District government incurs costs resulting from the death of a qualified patient ingesting a covered medication pursuant to this chapter in a public place, the District government shall have a claim against the estate of the qualified patient to recover such costs and reasonable attorney fees related to enforcing the claim.

(Feb. 18, 2017, D.C. Law 21-182, § 13, 63 DCR 15697.)

Penalties.

(a) A person who, without authorization of the patient, willfully alters or forges a request for a covered medication or conceals or destroys a rescission of a request for a covered medication with the intent or effect of causing the patient's death is punishable as a Class A felony.
(b) A person who, without authorization of the patient, willfully coerces or exerts undue influence on a patient to request or ingest a covered medication with the intent or effect of causing the patient's death is punishable as a Class A felony.
(Feb. 18, 2017, D.C. Law 21-182, § 14, 63 DCR 15697.)

Rules.

(a) The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, shall issue rules to:
(1) Develop the form to collect the medical record information required by § 7-661.06;
(2) Facilitate the collection of the medical record information required by § 7-661.06; and
(3) Provide for the return of and safe disposal of unused covered medications.
(b) The Mayor, pursuant to subchapter I of Chapter 5 of Title 2, may issue rules to implement the provisions of this chapter, including rules to:
(1) Specify the recommended methods by which a qualified patient, who so desires, may notify first responders of his or her intent to ingest a covered medication; and
(2) Establish training opportunities for the medical community to learn about the use of covered medications by qualified patients seeking to die in a humane and peaceful manner, including best practices for prescribing the covered medication.
(Feb. 18, 2017, D.C. Law 21-182, § 15, 63 DCR 15697.)

Construction.

(a) Nothing in this chapter may be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, active euthanasia, or any other method or medication not authorized under this chapter.
(b) Actions taken in accordance with this chapter do not constitute suicide, assisted suicide, mercy killing, or homicide.
(c) Nothing in this chapter shall be construed to authorize a qualified patient to ingest a covered medication in a public place.
(Feb. 18, 2017, D.C. Law 21-182, § 16, 63 DCR 15697.)

Freedom of Information Act Exemption.

The information collected by the Department pursuant to this chapter shall not be a public record and may not be made available for inspection by the public under subchapter II of Chapter 5 of Title 2, or any other law.
(Feb. 18, 2017, D.C. Law 21-182, § 17, 63 DCR 15697.)

Applicability.

Repealed.
(Feb. 18, 2017, D.C. Law 21-182, § 18, 63 DCR 15697; Dec. 13, 2017, D.C. Law 22-33, § 7018(a), 64 DCR 7652.)