Medical Assistance in Dying
Certification by the Administering Physician

I, _____, am the administering physician who is providing/administering
(print physician's name)
pharmaceutical agent(s) to _____ (the patient)
(print patient's name)
for the intended purpose of causing the patient's death at the patient's request.

I hereby certify that:

1. I am familiar with all of the requirements for providing medical assistance in dying to a patient set out in Schedule M of By-Law 11 of The College of Physicians & Surgeons of Manitoba ("the Schedule").
2. I am satisfied that**:**
    a. The patient is at least 18 years of age;
    b. The patient's medical decision making capacity to consent to receiving pharmaceutical agent(s) that will intentionally cause the patient's death has been established in accordance with the requirements of the Schedule;
    c. All of the requirements regarding assessing eligibility for medical assistance in dying and obtaining and documenting informed consent have been met. The following physicians were involved:

        i. _____
        [Print first and last names of the physician(s)]
        conducted the assessment(s) for patient eligibility as required.

        ii. _____
        [Print first and last names of the physician(s)]
        conducted the assessment(s) of the patient's medical decision making capacity and determined that the patient was competent to provide informed consent for medical assistance in dying as required.

        iii. _____
        [Print first and last names of the physician(s)]
        independently conducted the assessment(s) of the patient's medical decision making capacity and determined that the patient was competent to provide informed consent for medical assistance in dying as required.

Signed by me at _____, in the Province of Manitoba, this ____ day of _____, 20__.

_____ _____
WITNESS Administering Physician

_____ _____
Print Name of Witness Print Name of Administering Physician