

Voluntary assisted dying in Western Australia

How to fill in a Written Declaration

- These instructions will help you understand which parts of the Written Declaration need to be completed, and who needs to complete them.
- You can make a Written Declaration **after** your Coordinating and Consulting Practitioners have assessed you as eligible for access to voluntary assisted dying.
- The [Completing the Written Declaration](#) information sheet has more information about the Declaration, including who can be a witness and what to do if you aren't able to complete the Written Declaration yourself.
- If you need help contact:
 - your Coordinating Practitioner, or
 - the Statewide Care Navigator Service
Phone: 08 9431 2755
Email: VADCareNavigator@health.wa.gov.au

Part A. Patient information

Completed by

The patient OR another person on the patient's behalf.

Instructions

Is part A already filled in?

Yes

- Check to make sure information is correct.
- Cross out and rewrite any information that is incorrect.
- Move on to part **B. Coordinating Practitioner** information.

No

- Complete the fields highlighted in **yellow**.
- Other fields should also be completed if they are relevant.

A. Patient information	
Unique patient ID (from VAD-IMS)	861791
Title	<input checked="" type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other (please specify) <input type="text"/>
Family name	Alan
Given name	Citizen
Other given name(s)	<input type="text"/>
Date of birth (DD/MM/YYYY)	01/01/1950
Home address (line 1)	Hay Street Mall
Home address (line 2)	<input type="text"/>
Suburb	Perth
State	WA Postcode 6000
Is your mailing address different to your home address?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please complete the fields below.	
Mailing Address (line 1)	<input type="text"/>
Mailing Address (line 2)	<input type="text"/>
Suburb	<input type="text"/>
State	<input type="text"/> Postcode <input type="text"/>
Telephone number	08 9555 5555
Email address	<input type="text"/>

Part B. Coordinating Practitioner information

Completed by

If not already filled in by the practitioner, the patient OR another person on the patient's behalf can complete.

Instructions

Is part B already filled in?

Yes

- Check to make sure information is correct.
- Cross out and rewrite any information that is incorrect.
- Then move on to part **C. Patient Declaration**.

No

- Complete the fields highlighted in **yellow**.
- Other fields should also be completed if they are relevant.

B. Coordinating Practitioner information

Unique practitioner ID (from VAD-IMS) 505024

AHPRA Registration Number MED000000001

Title Mr Mrs Ms Miss Dr Other (please specify) _____

Family name Smith

Given name Amy

Other given name(s) _____

Work address (line 1) 1 St Georges Terrace

Work address (line 2) _____

Suburb Perth

State WA Postcode 6000

Is the Coordinating Practitioner's mailing address different to their work address? No Yes

If yes, please complete the fields below.

Mailing address (line 1) _____

Mailing address (line 2) _____

Suburb _____

State _____ Postcode _____

Telephone number 95555555

Email address vadims.bvt+Prac1@gmail.com

Part C. Patient Declaration

Completed by

The patient OR another person on the patient's behalf.

Instructions

Complete the **yellow** section.
Can the patient sign the Declaration?

Yes

- Complete the **green** section.

No

- Complete the **blue** section.

C. Patient Declaration

I, Mr Citizen Alan _____, declare that I make this request for access to _____ Patient Name
voluntarily assisted dying voluntarily and without coercion and I understand its nature and effect.

Signature of patient _____ Date (DD/MM/YYYY) _____
(in the presence of two eligible witnesses)

If the patient is unable to sign the Declaration, the section below applies

Another person can sign this Declaration on the patient's behalf, in the presence of the patient and the two eligible witnesses, if:

- the patient is unable to sign this Declaration themselves; and
- the patient has expressly directed the person to sign the Declaration; and
- the person is not either of the witnesses to this Declaration or the Coordinating or Consulting Practitioner for the patient; and
- the person has reached 18 years of age.

Name of person (print name) _____

Signature of person: _____ Date (DD/MM/YYYY) _____
(in the presence of the patient and two eligible witnesses)

Part D. Certification of witnesses to signing of Written Declaration

Completed by

The first witness.

Instructions

Did the patient sign the declaration themselves?

Yes

- Complete the **green** section.

No

- Complete the **blue** section.

The **yellow** section must **always** be completed.

D. Certification of witnesses to signing of Written Declaration

A person is an "ineligible witness" if they:

- are under 18 years of age;
- know or believe that they are a beneficiary under a will of the patient;
- know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are a family member of the patient; and
- are the Coordinating or Consulting Practitioner for the patient.

First witness

I, _____ Witness Name
am not knowingly an ineligible witness and certify that in my presence, and in the presence of the second witness, _____ Patient Name
appeared to freely and voluntarily sign this Declaration.

OR if patient directs another person to sign on their behalf:

I, _____ Witness Name
presence, _____ Patient Name
appeared to freely and voluntarily direct
_____ Other Person Name
to sign this Declaration and
_____ Other Person Name
signed this Declaration in the presence of
_____ Patient Name
myself and the second witness.

Signature of first witness _____ Date (DD/MM/YYYY) _____

Part E. Second witness

Completed by

The second witness.

Instructions

Did the patient sign the declaration themselves?

Yes

- Complete the **green** section.

No

- Complete the **blue** section.

The **yellow** section must **always** be completed.

E. Second witness

I, _____, am not knowingly an ineligible witness and certify that in my presence, and in the presence of the first witness, _____ appeared to freely and voluntarily sign this Declaration.

OR if patient directs another person to sign on their behalf:

I, _____, am not knowingly an ineligible witness and certify that in my presence, _____ appeared to freely and voluntarily direct _____ to sign this Declaration and _____ signed this Declaration in the presence of _____, myself and the first witness.

Signature of second witness: _____ Date (DD/MM/YYYY): _____

Part F. Communication

Completed by

The patient OR another person on the patient's behalf.
Interpreter (if used).

Instructions

Was the Written Declaration made with the assistance of an interpreter?

No

- Place a tick in the box next to 'No' and move on to the **Next steps** part of the form.

Yes

- Place a tick in the box next to 'Yes'.
- All fields in the **purple** section must be completed. Noting that the **red box** indicates the certification that must be completed by the interpreter only.

Once all sections are complete, give the Written Declaration to your Coordinating Practitioner.

F. Communication

Did you make the Written Declaration with the assistance of an interpreter?

No
 Yes

If yes, please complete the Interpreter information below.

Interpreter information (IF APPLICABLE)

What type of interpreter service was required?

Spoken language other than English
 Non-spoken communication (e.g. AUSLAN)

Title Mr Mrs Ms Miss Dr Other (please specify) _____

Family name _____

Given name _____

Other given name(s) _____

Telephone number _____

Email address _____

Accreditation details (Practitioner Number) _____

I, _____, certify that I have provided a true and correct translation of the material translated to assist _____ to make this Declaration.

Note: You must meet all of the criteria below to be an interpreter for this patient under the Act.

I, _____, certify that I:

- am accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- am **not** a family member of the patient;
- do **not** know or believe that I am a beneficiary under a will of the patient;
- do **not** know or believe that I may otherwise benefit financially or in any other material way from the death of the patient;
- am **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- am **not** directly involved in providing health services or professional care services to the patient.

Signature of interpreter: _____ Date (DD/MM/YYYY): _____

For stamp: _____

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