

VERIFICATION OF DEATH

I declare that I examined the body of:

Person's Name:			
On (date):		At (time):	
Location of examination of body:			

and I confirm that this person is dead.

In reaching this conclusion I relied upon the following:

Either –

(a) A clinical assessment, detailed below (ALL assessments must be ticked to confirm death)

First Assessment (minimum 10 minutes between) Second Assessment

<input type="checkbox"/> No signs of breathing for 1 minute	<input type="checkbox"/> No signs of breathing for 1 minute
<input type="checkbox"/> No palpable carotid or femoral pulse for 1 minute	<input type="checkbox"/> No palpable carotid or femoral pulse for 1 minute
<input type="checkbox"/> No audible heart sounds	<input type="checkbox"/> No audible heart sounds
<input type="checkbox"/> Pupils dilated and unreactive to light	<input type="checkbox"/> Pupils dilated and unreactive to light
Optional additional assessment – <input type="checkbox"/> Cardiac rhythm asystole on defibrillator/monitor	

Or –

(b) The condition of the body, detailed below (At least ONE box must be ticked to confirm death)

<input type="checkbox"/> The body had visible traumatic injuries incompatible with life
<input type="checkbox"/> The body showed signs of decomposition incompatible with life

Name (please print):	Reg No. or Identifier or Employee No:	
Signature of person making declaration:		
Name of Employer or Medical Practice:		
Practitioner Scope:	<input type="checkbox"/> Registered Medical Practitioner <input type="checkbox"/> Intensive Care Paramedic or Paramedic or Emergency Medical Technician <input type="checkbox"/> Registered Nurse or Nurse Practitioner <input type="checkbox"/> Registered Midwife	

Only persons falling within one of the above practitioner scopes can sign this declaration.