The End of Life Option Act

Loma Linda Grand Rounds

January 27, 2016

Presented by

Christine J. Wilson, R.N., J.D.

David M. Chooljian, M.D., J.D.

Tyler & Wilson, LLP

5455 Wilshire Boulevard, Suite 1925

Los Angeles, CA 90036

Tel: (323) 655-7180 Fax: (323) 655-7122

Email: inquiries@tyler-law.com

T&W

TYLER & WILSON

A LIMITED LIABILITY PARTNERSHIP

What the Act Does

- Allows a mentally competent adult who is determined by a physician to be suffering from a terminal disease to request a drug to be prescribed for the purpose of ending his or her life.
- The full text of the law (ABX2-15) is 25 ½ pages and is available online:
  - https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15
- Adds Health and Safety Code § 443
- Follows § 442 et. seq. requiring health care providers to provide terminally ill patients (or their surrogates) with notice of their right to information and counseling regarding legal end-of-life options.

Some History of the Statute

- Originally introduced as SB-128 in January of 2015 – passed through senate Health, Judiciary and Appropriations committees, passed 23/15 in the Senate then stalled in the Assembly.
- Reintroduced as ABX2-15 in August of 2015 during the “second extraordinary session”. Passed by Assembly (44/35) and Senate (23/15); signed by Governor Brown on October 5, 2015
- Effective date will be 91 days after conclusion of second extraordinary session when it was introduced (still in session – session must end by November, 2016)

T&W
TYLER & WILSON
A LIMITED LIABILITY PARTNERSHIP

Who May Use the Statute?

- Adult California resident with a terminal disease who has capacity to make health care decisions
- Personally requests the aid in dying drug and is able to self administer: 2 oral requests 15 days apart followed by a witnessed written request
- Attending physician must offer opportunity to rescind before writing the actual prescription

Physician Obligations

- Determine capacity and that patient qualifies under law
- Refer to mental health specialist if indications of mental disorder exist; specialist must verify capacity and that patient not suffering from impaired judgment
- Verify terminal disease diagnosis
- Determine that request is voluntary and decision is informed
- Refer to another MD to confirm diagnosis and capacity
- Confirm absence of coercion or undue influence by private conversation
- Counsel patient regarding certain enumerated topics
- Complete state mandated forms and turn in all documents to the State Department of Public Health (DPH)

Documentation

State mandated forms

- Request for Aid in Dying Drug[1] (witnessed)
- Interpreter declaration (if used)
- Final attestation for Aid in Dying Drug
- Attending physician checklist and compliance form[1]
- Consulting physician compliance form[1]
- Attending physician follow-up form[2]

[1] Must turn in to DPH within 30 days of writing prescription

[2] Must turn in to DPH within 30 days of death from *any* cause if prescription was written

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I, ..., am an adult of sound mind and a resident of the State of California.

I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I, ..., am an adult of sound mind and a resident of the State of California.

I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH
	PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE)	

B	ATTENDING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

C	CONSULTING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

D ELIGIBILITY DETERMINATION

1. TERMINAL DISEASE

2. CHECK BOXES FOR COMPLIANCE:

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that patient is a resident of California.
- ☐ 3. Determination that patient has the capacity to make medical decisions**
- ☐ 4. Determination that patient is acting voluntarily.
- ☐ 5. Determination of capacity by mental health specialist, if necessary.
- ☐ 6. Determination that patient has made his/her decision after being fully informed of:
- ☐ a) His or her medical diagnosis; and
- ☐ b) His or her prognosis; and
- ☐ c) The potential risks associated with ingesting the requested aid-in-dying drug;
- ☐ d) The probable result of ingesting the aid-in-dying drug;
- ☐ e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

E ADDITIONAL COMPLIANCE REQUIREMENTS

- ☐ 1. Counseled patient about the importance of all of the following:
- ☐ a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it;
- ☐ b) Having another person present when he or she ingests the aid-in-dying drug;
- ☐ c) Not ingesting the aid-in-dying drug in a public place;
- ☐ d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and
- ☐ e) Participating in a hospice program or palliative care program.
- ☐ 2. Informed patient of right to rescind request (1st time)
- ☐ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.
- ☐ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion
- ☐ 5. First oral request for aid-in-dying: _____/_____/_____ Attending physician initials:_____
- ☐ 6. Second oral request for aid-in-dying:_____/_____/_____ Attending physician initials:_____
- ☐ 7. Written request submitted: _____/_____/_____ Attending physician initials:_____
- ☐ 8. Offered patient right to rescind (2nd time)

F PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder

Mental health specialist's information, if applicable:

MENTAL HEALTH SPECIALIST NAME

MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER

MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE)

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

G	MEDICATION PRESCRIBED	
	PHARMACIST NAME	TELEPHONE NUMBER ( ) —

1. Aid-in-dying medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
2. Antiemetic medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
3. Method prescription was delivered:
   - ☐ a. In person
   - ☐ b. By mail
   - ☐ c. Electronically
4. Date medication was prescribed:_____/_____/_____

	X	PHYSICIAN'S SIGNATURE	DATE
		NAME (PLEASE PRINT)	

** "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

*****"Mental Health Specialist" means a psychiatrist or a licensed psychologist.

CONSULTING PHYSICIAN COMPLIANCE FORM

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B	ATTENDING PHYSICIAN	
	ATTENDING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) . —

C	CONSULTING PHYSICIAN'S REPORT	
	1. TERMINAL DISEASE	DATE OF EXAMINATION(S)

2. Check boxes for compliance. *(Both the attending and consulting physicians must make these determinations.)*

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that patient has the mental capacity to make medical decisions.**
- ☐ 3. Determination that patient is acting voluntarily.
- ☐ 4. Determination that patient has made his/her decision after being fully informed of:
- ☐ a) His or her medical diagnosis; and
- ☐ b) His or her prognosis; and
- ☐ c) The potential risks associated with taking the drug to be prescribed; and
- ☐ d) The potential result of taking the drug to be prescribed; and
- ☐ e) The feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.

D PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder

MENTAL HEALTH SPECIALIST'S NAME	TELEPHONE NUMBER ( ) —	DATE

E CONSULTANT'S INFORMATION

X	PHYSICIAN'S SIGNATURE	DATE
	NAME (PLEASE PRINT)	
MAILING ADDRESS		
CITY, STATE AND ZIP CODE		TELEPHONE NUMBER ( ) —

** "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

****"Mental Health Specialist" means a psychiatrist or a licensed psychologist.

ATTENDING PHYSICIAN FOLLOW-UP FORM

The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health to accept this form, it must be signed by the attending physician, whether or not he or she was present at the patient's time of death.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: _____/_____/_____

Patient name: _____

Attending physician name: _____

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

- ☐ **Aid-in-dying drug** (lethal dose) → Please sign below and go to page 2.
  Attending physician signature: _____
- ☐ **Underlying illness** → There is no need to complete the rest of the form. Please sign below.
  Attending physician signature: _____
- ☐ **Other** → There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign
  Please specify:

  _____

  _____

Attending physician signature:_____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

☐ The attending physician was present at the time of death.

→ The attending physician must complete this form in its entirety and sign Part A and Part B.

☐ The attending physician was not present at the time of death, but another licensed health care provider was present.

→ The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of the form.

☐ Neither the attending physician nor another licensed health care provider was present at the time of death.

→ Part A may be left blank. The attending physician must complete and sign Part B of the form.

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART A: To be completed and signed by the attending physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?

- ☐ Yes
- ☐ No

If no: Was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?

- ☐ Yes, another physician
- ☐ Yes, a trained health-care provider/volunteer
- ☐ No
- ☐ Unknown

2. Was the attending physician at the patient's bedside at the time of death?

- ☐ Yes
- ☐ No

If no: Was another physician or a licensed health care provider present at the patient's time of death?

- ☐ Yes, another physician or licensed health care provider
- ☐ No
- ☐ Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying?
_____/_____/_____ (month/day/year) ☐ Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?
_____/_____/_____ (month/day/year) ☐ Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?

- ☐ Private home
- ☐ Assisted-living residence
- ☐ Nursing home
- ☐ Acute care hospital in-patient
- ☐ In-patient hospice resident
- ☐ Other (specify)_____
- ☐ Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?

Minutes_____ and/or Hours_____ ☐Unknown

7. What was the time between lethal medication ingestion and death?

Minutes_____ and/or Hours_____ ☐Unknown

ATTENDING PHYSICIAN FOLLOW-UP FORM

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

- ☐ Yes- vomiting, emesis
- ☐ Yes-regained consciousness
- ☐ No Complications
- ☐ Other- Please describe:_____
- ☐ Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

- ☐ Yes- Please describe:_____
- ☐ No
- ☐ Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

Signature of attending physician present at time of death: _____

Name of Licensed Health Care Provider present at time of death if not attending physician:_____

Signature of Licensed Health Care Provider: _____

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART B: To be completed and signed by the attending physician

12. On what date was the prescription written for the aid-in-dying drug? ____/____/____

13. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

14. What type of health-care coverage did the patient have for their underlying illness? (*Check all that apply.*)

- ☐ Medicare
- ☐ Medi-cal
- ☐ Covered California
- ☐ V.A.
- ☐ Private Insurance
- ☐ No insurance
- ☐ Had insurance, don't know type

15. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug Please check "yes," "no," or "Don't' know," depending on whether or not you believe that concern contributed to their request (Please check as many boxes as you think may apply)

A concern about . . .

- **His or her terminal condition representing a steady loss of autonomy**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **The decreasing ability to participate in activities that made life enjoyable**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **The loss of control of bodily functions**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Persistent and uncontrollable pain and suffering**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **A loss of Dignity**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Other concerns** (specify): _____

Signature of attending physician: _____

Medical Record Requirements

Medical Record:

- Oral and written requests
- Diagnosis and prognosis
- Capacity
- Qualification of patient (age, residence, etc.)
- Mental health assessment if performed
- Consulting physician evaluation
- Offers to rescind
- Specific notes documenting compliance with each statutory requirement

Death Certificates

- Not addressed by the Act
- However, use of drug prescribed under the Act is not suicide
- Guidance from CMA legal counsel
  - Do not list suicide as cause of death
  - List cause that MD feels is most accurate
  - Act does not preclude MD from listing the underlying terminal illness

Prohibitions

- Contract, will or other agreement may not be conditioned upon making or rescinding request
- Sale, issuance or premium rate of life or health insurance may not be conditioned upon or affected by request
- Insurer may not provide information about aid in dying unless requested by insured or MD acting at insured's request
- Insurer may not combine treatment denial notification with aid in dying information

Immunities

- No liability solely due to presence at time the drug is ingested
- No liability for person who assists with preparation of drug; assistance with ingestion is prohibited
- No liability for health care provider who refuses to participate or directs employees not to participate

Legal Protection for Physicians

- May not be required to participate
- May opt out of giving information on referrals to patients for reasons of conscience, morality or ethics (but must provide medical record)

Legal Protection for Physicians

- Protects MD from criminal, civil, administrative, disciplinary, employment, credentialing, medical staff actions, medical board actions and other consequences if he or she:
  - Declines to participate in any activities covered by the Act
  - Participates in good faith compliance with the requirements of the Act

Legal Protection for Physicians

- Actions taken in accordance with the Act are not suicide, assisted suicide, homicide or elder abuse

More information: CMA Document #3459 published by CMA legal counsel on January 20, 2016 http://www.cmanet.org/

Felonies

- Altering or forging request
- Destroying a withdrawal or rescission
- Knowingly coercing or exerting undue influence on patient to request lethal drugs
- Lethal injection, mercy killing or active euthanasia are still homicide
- Compliance with the statute is not homicide

Efforts to Repeal

Seniors against Suicide attempted to gather sufficient signatures for a ballot referendum to repeal the statute but appear to have been unable to obtain enough signatures.

“Our work to oppose this law will not be over. We will explore other options including legal action.”

- Dr. Mark Hoffman

stopassistedsuicide.com

Disability Rights?

- No unified voice
- Disability Rights Legal Center (disabilityrightslegalcenter.org)
  - Counsel in Brody v Harris a San Francisco Superior Court case seeking declaration that Penal Code § 401 (assisting in suicide) does not apply to physician aid in dying)
- Opposing organizations listed at Californians Against Assisted Suicide (noassistedsuicideca.org)
  - No information as to the basis for objection by each organization nor whether the ABX2-15 safeguards would satisfy the organization's concerns
  - Unknown what action, if any, will be taken

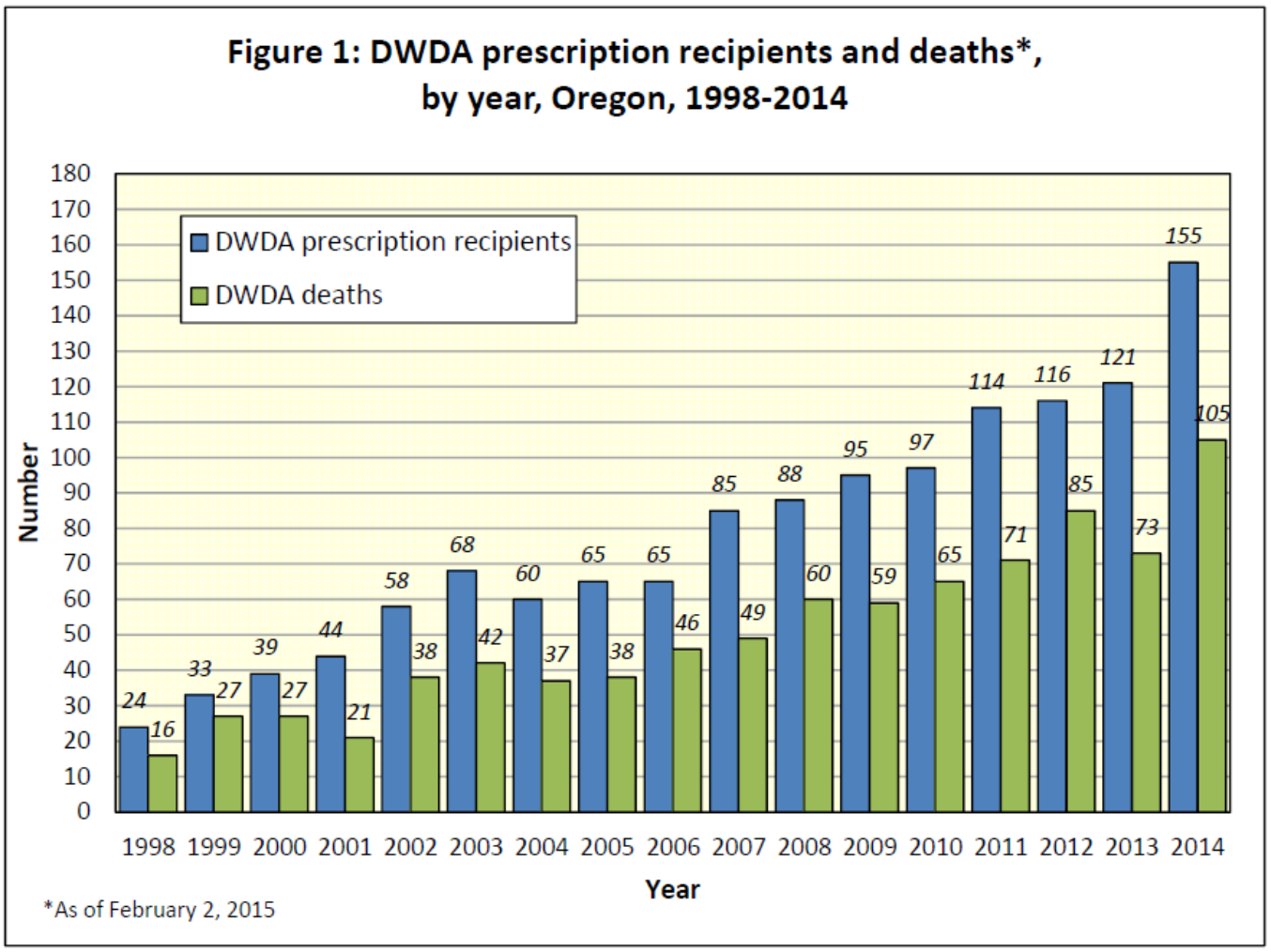
Experience in Other States

- Oregon: First to have physician assisted suicide law
- Death With Dignity Act passed by 51% popular vote November 8, 1994
- Attempt to repeal in 1997 rejected by 60% of voters
- Upheld by US Supreme Court in 2006 holding that the federal Controlled Substances Act does not empower Attorney General to prohibit MD prescribing of fatal controlled substances for this specific purpose

Experience in Other States

- Washington: Ballot initiative November 4, 2008 passed by 58%
- Montana: Supreme Court - December 5, 2008 “no indication that physician aid in dying provided to terminally ill, mentally competent adult patients is against public policy”. Physicians arguably shielded but no statutory procedures
- Vermont: Legislative Act became law May 20, 2013
- Legislative Acts in OR, CA, WA & VT have more similarities than differences

The Oregon Experience



Tyler & Wilson
A Limited Liability Partnership

The Oregon Experience

- Since the law passed in 1997, a total of 1327 people have had DWDA prescriptions written and 859 patents have died from ingesting medications prescribed under the DWDA.
- Of the 105 DWDA deaths during 2015, most (67.6%) were aged 65 years or older. The median age at death was 72 years. As in previous years, decedents were commonly white (95.2%) and well-educated (47.6% had a least a baccalaureate degree).

The Oregon Experience

- In 2014 79.4% of patients were diagnosed with cancer and 16.2% were diagnosed with amyotrophic lateral sclerosis (ALS).
- Most (89.5%) patients died at home, and most (93.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death.
- Lethal medication used
  - Secobarbital (60.0%)
  - Pentobarbital (39.0%)
  - Other (1.0%)

The Oregon Experience

- The three most frequently mentioned end-of-life concerns were: loss of autonomy (91.4%), decreasing ability to participate in activities that made life enjoyable (86.7%) and loss of dignity (71.4%).
- Eighty-three physicians wrote 155 prescriptions during 2014 (between 1 and 12 prescriptions per physician).
- During 2014, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

The Oregon Experience

Characteristics and end-of-life care 2014 (N=105)

- Marital Status
  - Married (45.7%)
  - Widowed (24.8%)
  - Never married (5.7%)
  - Divorced (23.8%)
- Education
  - Less than high school (5.7%)
  - High school graduate (21.9%)
  - Some college (24.8%)
  - Baccalaureate or higher (47.6%)

Age at death (years)

- 18-54 (5.8%)
- 55-85+ (94.3%)

- Race
  - 95.2% white
  - 4.8% identified as other than white

T&W

TYLER & WILSON

A LIMITED LIABILITY PARTNERSHIP

Issues to Consider

- Malpractice Insurance
- MD responsibility to determine lack of coercion or undue influence
- Risk if statutory compliance incomplete
- Death certificate completion
- Standard of care and practice in this untested environment
- Are the procedures unduly burdensome?
- Will aid in dying be available to all who request and qualify?

The VA Perspective

"Practitioners functioning in their VA capacity are prohibited from participating in PAS and euthanasia, including participating in evaluations, referrals to self or others, or records reviews related to requests for PAS or euthanasia by VA patients, even when such actions are allowed in non-VA facilities by laws of the state in which the VA facility is located or the practitioner resides or is licensed."

The VA Perspective - Basis

- Assisted Suicide Funding Restriction
- 42 United States Code §14401
  - Federal funds may not be used to pay for items & services "the purpose of which is to cause (or assist in causing) the suicide…of any individual."
  - §14402(a): includes "assisted suicide"
  - §14402(d)(1)(I): Veterans medical care
- TMS: Responding to Requests to Hasten Death (Course 16749)

The VA Perspective - Limits

- May **not**:
  - Perform PAS as VA practitioner/on VA property.
  - Refer for PAS, including to self.
  - Act as consulting physician (mental health/mandatory).
- Providing basic information (including lack of service at VA) not expressly prohibited.

Thank you for your time and attention.

Christine J. Wilson, R.N., J.D.
David M. Chooljian, M.D., J.D.

Note: This class is intended to provide general information only. For specific legal advice applicable to your personal situation, please consult an attorney. No attorney-client relationship with the firm Tyler & Wilson, LLP is intended to be created by this presentation.

Tyler & Wilson, LLP
5455 Wilshire Boulevard, Suite 1925
Los Angeles, CA 90036
Tel: (323) 655-7180 Fax: (323) 655-7122
Email: inquiries@tyler-law.com

TYLER & WILSON
A LIMITED LIABILITY PARTNERSHIP