

[Your Name]  
[Your Address]  
[City, State, Zip Code]  
[Email Address]  
[Phone Number]  
[Date]

[Recipient's Name]  
[Recipient's Title]  
[Medical Facility Name]  
[Facility Address]  
[City, State, Zip Code]

Dear [Recipient's Name],

Subject: Do Not Resuscitate (DNR) Appointment

I am writing to formally designate a Do Not Resuscitate (DNR) order concerning my medical treatment in the event of a life-threatening situation where resuscitation may be necessary.

Patient Information:

- Full Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Medical Record Number: [Your Medical Record Number]

In accordance with my wishes regarding end-of-life care and to ensure my preferences are known and respected, I request that my DNR status be recorded in my medical file. I understand the implications of this decision, and it is made voluntarily.

Please find attached the necessary documents, including my state-specific DNR form, duly filled and signed.

Thank you for your attention to this important matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]

Enclosures: [List any attached documents]