Do Not Resuscitate (DNR) Directive

Full Name of Patient

Date of Birth

Address

Directive

I, the undersigned, being of sound mind, hereby direct that in the event of my heart stopping or if I stop breathing, no attempts be made to resuscitate me. I request that no cardiopulmonary resuscitation (CPR), advanced cardiac life support, or artificial ventilation be performed, and that I am allowed to die naturally with only comfort care.

This directive reflects my wishes and applies to all healthcare professionals involved in my care. I request that this document be made part of my medical records, and that my family, healthcare agent(s), and care team are notified of my wishes.

Patient (or Legal Representative) Acknowledgment

Printed Name

Signature

Date

Physician Confirmation

Physician Name

Physician Signature

Date

Medical License Number

Witness

Witness Name & Signature

Date