MONTH DATE, YEAR

**McLaren Region -**

**Office Name**

STREET ADDRESS, SUITE #

CITY, MI ZIP

tel: (000) 000-0000

fax: (000) 000-0000

mclaren.org/officeURL

Dear Patient:

To better serve your medical needs, we are pleased to announce the addition of First Last Name, Credential, to our office. Dr./Ms./Mr. Provider Last Name will begin seeing patients on Month Date, Year.

Dr./Mr./Mis. Last comes to us from XXXX and earned their medical degree/degree at University Name in City, State. He/She has extensive experience in specialty and is passionate about providing high-quality, patient-centered care.

If you have questions or would like to schedule an appointment with Dr./Mr./Ms. Last, please call our office at (000) 000-0000.

Thank you for entrusting McLaren with your health care needs.

Sincerely,

*Upload signature(s) in the Special Notes/Attachments section of Request Form.*

Director First Last Name

Region Name

McLaren Medical Group