Medical Provider's Name: _____

Date: _____

Recipient Name: _____
Company Name: _____
Company Address: _____

Hello,

This is a letter of support for [insert patient name] _____, confirming that he/she has [insert medical condition/disability] _____ and would greatly benefit from [insert reasonable accommodation] _____.

[Insert disability] _____ is supported by [insert objective medical evidence of condition] _____. (Consider including: formal diagnosis, onset date; diagnostic procedures undertaken to diagnose condition and rule out illnesses that cause similar symptoms; treatments undergone to mitigate effects of condition on everyday ability to function, including ability to perform normal job duties; outlook for disability, including whether condition should improve/worsen with time, and overall timeframe of progression/regression of disability; symptoms suffered and how symptoms affect everyday life, including ability to work).

My medical opinion on [insert patient's name] _____ limitations are [insert medical opinion] _____. (Consider including information about how well patient can: sit, stand, stoop, crouch, walk, balance and kneel; use hands and arms, including reaching, grasping, and lifting; lift certain weights of if patient has restrictions on amount of weight they can lift/carry; complete routine or repetitive tasks, respond to reflexes, dexterity functionality, utilize range of motion).

The medical evidence supports my opinion as physician on [insert patient's name] _____ condition.

Sincerely,

Medical Provider's Name_____

Position: _____
Company Name: _____

Note: inspired by https://www.disability-benefits-help.org/disability-tips/letter-of-support