[Health Care Provider Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Employer Name/HR Department]
[Company Name]
[Address]
[City, State, Zip Code]

RE: Medical Certification for Reasonable Accommodation
Patient Name: [Patient Name]
Date of Birth: [DOB]

To Whom It May Concern,

I am the treating [Job Title/Medical Specialty] for [Patient Name]. I am writing to support my patient's request for reasonable workplace accommodations due to a medical condition that qualifies as a disability under the Americans with Disabilities Act (ADA).

The patient has a physical or mental impairment that substantially limits one or more major life activities. Specifically, this condition impacts the patient's ability to perform the following functions: [List functions, e.g., standing for long periods, lifting, concentrating, etc.].

To assist the patient in performing their essential job duties, I recommend the following workplace accommodations:

- [Accommodation Recommendation 1]
- [Accommodation Recommendation 2]

These accommodations are medically necessary starting [Start Date] and are expected to be required until [End Date or "Permanently"].

Please contact my office if you require additional information regarding these functional limitations.

Sincerely,

[Signature]

[Printed Name of Medical Provider]
[Medical License Number]