

[Physician Name/Medical Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [Employer Name/Human Resources Department]
[Company Name]
[Address]

RE: Medical Necessity for Ergonomic Workplace Modifications for [Patient Name]

To Whom It May Concern,

I am the treating physician for [Patient Name], who is currently under my care for [mention condition briefly, e.g., chronic musculoskeletal strain / repetitive stress injury].

Based on my clinical evaluation and the patient's job duties, I have determined that certain ergonomic modifications to their workstation are medically necessary to prevent further injury, alleviate symptoms, and allow the patient to perform their essential job functions safely.

I recommend the following modifications be implemented:

- [Recommendation 1, e.g., Height-adjustable sit-stand desk]
- [Recommendation 2, e.g., Ergonomic task chair with lumbar support]
- [Recommendation 3, e.g., Split ergonomic keyboard and vertical mouse]
- [Recommendation 4, e.g., Dual monitor risers to maintain eye level]

In addition to these equipment changes, I recommend that the patient be allowed to [e.g., take 5-minute stretching breaks every hour].

These adjustments are intended to [e.g., reduce spinal compression / minimize ulnar deviation] and are vital for the patient's long-term health and continued productivity. Please let me know if you require further documentation or a formal functional capacity evaluation.

Thank you for your cooperation in supporting [Patient Name]'s health and safety.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]