[Date]

[Healthcare Provider's Name]
[Medical Credentials/Title]
[Clinic/Hospital Name]
[Address]
[Phone Number]

To: [Employer Name/Human Resources Department]
Regarding: [Patient/Employee Name]
Date of Birth: [DOB]

To Whom It May Concern,

I am the treating [Type of Provider] for [Patient Name]. I have been providing medical care for this individual since [Date].

The patient has a [permanent/temporary] medical condition that results in functional limitations in the following areas: [e.g., vision, manual dexterity, cognitive processing, or concentration]. These limitations impact the patient's ability to utilize standard computer software interfaces as currently configured.

To assist the patient in performing their essential job functions, I recommend the following software-based accommodations:

- [Specific software name, e.g., screen reader, speech-to-text, or magnification software]
- [Specific configuration, e.g., high-contrast themes or simplified user interface]
- [Any other digital tool or technical adjustment]

These accommodations are medically necessary to [e.g., reduce eye strain, prevent physical repetitive strain, or allow for effective information processing].

Please contact my office if you require further clarification regarding the functional limitations associated with this request.

Sincerely,

[Signature]
[Printed Name]
[Medical License Number]