[Physician or Healthcare Provider Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Recipient Name or Training Coordinator]
[Organization/Company Name]
[Address]
[City, State, Zip Code]

Subject: Medical Verification for Training Accommodations

To Whom It May Concern,

I am the treating healthcare provider for [Patient Name], who is currently under my care. I am writing to verify that [Patient Name] has a medical condition that requires specific accommodations to participate effectively in the upcoming training program titled "[Name of Training Program]," scheduled for [Date/Time].

Due to [Patient Name]'s condition, I recommend the following accommodations:

- [Insert accommodation 1, e.g., Frequent rest breaks]
- [Insert accommodation 2, e.g., Ergonomic seating or standing desk]
- [Insert accommodation 3, e.g., Written materials in large print]
- [Insert accommodation 4, e.g., Permission to use a recording device]

These accommodations are medically necessary to ensure the patient can access the training material and perform tasks without compromising their health. These requirements are expected to be necessary for [Duration, e.g., the duration of the course / the next six months].

Please feel free to contact my office at [Phone Number] if you require further clarification regarding these medical recommendations. Thank you for your assistance in supporting [Patient Name]'s professional development.

Sincerely,

[Signature of Medical Professional]
[Typed Name and Credentials]
[License Number]