

**Date:** [Insert Date]

**To:** [Clinic Manager's Name]

[Clinic Name]

[Department]

**RE: Letter of Medical Necessity for Workplace Accommodation**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

To whom it may concern,

I am the treating physician for [Patient Name]. Due to a diagnosed medical condition affecting the lumbar spine, specifically [Optional: Insert Diagnosis/ICD-10 Code], it is medically necessary for the patient to use an ergonomic lumbar support cushion while performing their professional duties at the clinic.

The patient's role involves prolonged periods of sitting, which currently exacerbates their symptoms of [List symptoms, e.g., chronic lower back pain, nerve compression, or muscle fatigue]. The use of a specialized lumbar support cushion is required to maintain proper spinal alignment, reduce intradiscal pressure, and prevent further injury or functional decline.

I am formally recommending the following accommodation:

- Provision of a high-density foam or gel-infused lumbar support cushion designed for office/clinic seating.

This medical equipment is essential for the patient to perform the essential functions of their job safely and effectively. Should you require any further documentation or clarification regarding this clinical recommendation, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical License Number]

[Clinic/Practice Name]