[Doctor's Name/Medical Practice Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Medical Recommendation for Reduced Work Hours - [Patient's Full Name]

To Whom It May Concern,

I am the treating physician for [Patient's Name], who is currently under my medical care. Due to a diagnosed medical condition, it is my professional recommendation that [Patient's Name] undergo a temporary reduction in their work schedule to support their health and recovery.

Effective [Start Date], I recommend that the patient's work hours be limited to [Number] hours per day and [Number] hours per week. This schedule should follow these specific restrictions: [e.g., no night shifts, frequent breaks, or no more than 4 consecutive hours].

I anticipate these restrictions will remain in place until [End Date/Expected Re-evaluation Date]. At that time, I will reassess the patient's condition to determine if they can return to their full-time duties or if further accommodations are necessary.

Please let us know if you require any additional documentation regarding this medical necessity, while respecting the patient's right to medical confidentiality.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[Medical License Number]
[Contact Information]