

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

[Date]

To [Employer Name / HR Department]:

I am writing this letter on behalf of my patient, [Employee Name], regarding their request for workplace accommodations. [Employee Name] is currently under my care for a medical condition that qualifies as a disability under the Americans with Disabilities Act (ADA) or applicable local laws.

Due to this medical condition, the patient has the following functional limitations that affect their ability to perform certain job duties:

- [Description of limitation 1]
- [Description of limitation 2]

To assist the patient in performing the essential functions of their job, I recommend the following workplace accommodations/exemptions:

- [Exemption/Accommodation 1, e.g., Remote work, modified schedule]
- [Exemption/Accommodation 2, e.g., Ergonomic equipment, frequent breaks]

These accommodations are medically necessary and are expected to be required for [Duration: e.g., 6 months, indefinitely, or until a specific date].

Please feel free to contact my office if you require further clarification regarding these medical restrictions. Thank you for your assistance in supporting my patient's health and professional productivity.

Sincerely,

[Physician Signature]

[Physician Printed Name]  
[Medical License Number]