Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Claim/Reference Number: [Reference Number]

To Whom It May Concern,

I am the attending physician for [Patient Name], who has been under my care since [Date]. I am writing to provide a formal statement regarding this patient's physical and cognitive capabilities as they relate to their functional abilities and work capacity.

Diagnosis and Treatment:
The patient is currently being treated for [Diagnosis/Medical Condition]. The current treatment plan includes [Medications/Therapy/Surgery].

Physical Capabilities and Restrictions:
Based on my clinical evaluation, the patient's physical limitations are as follows:

- **Lifting/Carrying:** [e.g., Maximum 10 lbs occasionally]
- **Standing/Walking:** [e.g., Up to 2 hours in an 8-hour workday]
- **Sitting:** [e.g., Up to 6 hours in an 8-hour workday with frequent breaks]
- **Postural Constraints:** [e.g., No bending, stooping, or climbing ladders]
- **Reaching/Handling:** [e.g., Limited overhead reaching with right arm]

Cognitive and Mental Capabilities:
The patient exhibits the following functional status regarding mental tasks:

- **Attention/Concentration:** [e.g., Capable of sustained focus for 2-hour increments]
- **Stress Tolerance:** [e.g., Able to handle low-stress environments only]
- **Interaction:** [e.g., No limitations in interacting with public or co-workers]

Physician's Conclusion:
In my professional medical opinion, the patient is currently [select one: Fit for Duty / Fit for Light Duty with Restrictions / Unable to Work]. These restrictions are expected to remain in place until [Date or Duration].

Should you require any further documentation or clarification regarding this patient's medical status, please contact my office.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]

[Phone Number]
[Email Address]