[Date]

[Recipient Name/Department]
[Organization Name]
[Address]
[City, State, Zip Code]

Subject: Medical Necessity for Screen Reader Assistive Technology

To whom it may concern,

I am writing to formally recommend the provision of a screen reader assistive device/software for my patient, **[Patient Name]**, (DOB: **[Date of Birth]**). **[Patient Name]** is currently under my care for **[Specific Diagnosis/Visual Impairment]**.

Due to this condition, the patient's visual acuity is measured at **[Visual Acuity, e.g., 20/200]**. This impairment significantly limits their ability to read standard printed text, navigate digital interfaces, and perform daily tasks independently.

To mitigate these challenges, it is medically and functionally necessary for the patient to utilize a screen reader (such as **[Specific Software/Device Name, e.g., JAWS, NVDA, or specialized hardware]**). This technology will allow the patient to:

- Convert digital text into synthesized speech or Braille output.
- Access essential information for education, employment, and healthcare.
- Maintain independence in daily living and communication.

I certify that the requested assistive technology is an essential accommodation for this patient's visual disability. Please feel free to contact my office at **[Phone Number]** if you require further documentation or clinical details.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[Title/Medical Specialty]
[Medical License Number]
[Clinic/Hospital Name]