Date: [Date]

To: [Employer Name / Human Resources Department]
From: [Physician/Provider Name]
Subject: Letter of Medical Necessity for Assistive Device

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I am the treating provider for [Patient Name]. Due to a diagnosed medical condition, specifically [Diagnosis/Condition, e.g., Chronic Lower Back Pain or Lumbar Radiculopathy], the patient requires a reasonable workplace accommodation to perform their duties as a Medical Assistant safely and effectively.

The patient's current job functions require prolonged periods of sitting and/or standing, which exacerbates their symptoms and limits their functional capacity. To mitigate physical strain and prevent further injury, I am prescribing the following assistive device as a medical necessity:

- **Device:** Adjustable Sit-Stand Desk / Desktop Converter

This device will allow the patient to alternate between sitting and standing positions throughout the workday, which is essential for managing their condition and maintaining productivity. I recommend that the patient be allowed to change positions every [Number] minutes as needed for pain management.

Please contact my office at [Phone Number] if you require further clarification regarding this medical recommendation.

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Medical Practice Name]
[NPI Number]