[Date]

[Healthcare Provider Name]
[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

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

RE: Medical Necessity for Work Accommodations

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

To Whom It May Concern,

I am the treating healthcare provider for [Patient Name], who is currently employed as a Pharmacy Technician at your facility. Due to an underlying medical condition, it is medically necessary for this patient to have specific work restrictions regarding prolonged standing.

Effective [Start Date], please implement the following workplace accommodations:

- The patient is restricted from standing or walking for more than [Number] consecutive minutes.
- The patient requires a [Number] minute seated break for every [Number] minutes spent standing.
- The patient should be provided with a stool or chair at their workstation to allow for tasks to be performed while seated whenever possible.
- The patient should avoid heavy lifting exceeding [Number] pounds while in a standing position.

These restrictions are expected to remain in place until [End Date/Next Evaluation Date]. These accommodations are necessary to prevent further injury and to manage the patient's current health status while allowing them to perform their essential job functions.

Thank you for your cooperation in supporting this patient's health and safety. Please contact my office at [Phone Number] if you require further clarification.

Sincerely,

[Signature]
[Printed Name of Healthcare Provider]

[Credentials/Title]
[License Number]