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

[Date]

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

RE: Medical Necessity for Ergonomic Seating Accommodation - [Employee Name]

To whom it may concern,

[Employee Name] is currently under my care following a surgical procedure performed on [Date of Surgery]. As part of their post-surgical recovery and to ensure a safe return to work, it is medically necessary for them to be provided with ergonomic seating accommodations.

Due to the nature of the surgery, the patient requires a workspace setup that minimizes physical strain and supports proper spinal alignment. Specifically, the following features are recommended for their seating:

- Adjustable lumbar support to maintain the natural curve of the spine.
- Adjustable seat height and tilt to ensure proper hip and knee alignment.
- Padded armrests to reduce strain on the shoulders and neck.
- High-density foam or specialized cushioning to alleviate pressure on the surgical site.

These accommodations are required starting [Start Date] and are expected to be necessary for a period of [Duration/Months], at which time the patient's physical status will be re-evaluated.

Providing this ergonomic equipment will allow [Employee Name] to perform their essential job functions while preventing post-operative complications or re-injury. If you require further medical documentation or have questions regarding these requirements, please contact my office.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]