Date: [Insert Date]

To: [Recipient Name/Employer/School Administration]

From: [Doctor's Name, MD/DO/NP/PA]
[Medical Practice Name]
[Phone Number]

RE: Medical Necessity for Unrestricted Restroom Access
Patient Name: [Patient Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

This letter is to certify that my patient, [Patient Name], is currently under my care following a recent surgical procedure performed on [Date of Surgery].

Due to the nature of their recovery and specific post-operative medical requirements, it is medically necessary for [Patient Name] to have immediate and unrestricted access to restroom facilities. This access must be granted without delay or the need for advanced notification whenever the need arises.

This medical requirement is effective immediately and is expected to remain in place until [Date or "further notice"]. Failure to provide timely access to a restroom may result in physical discomfort, complications, or interference with the surgical healing process.

We appreciate your cooperation in accommodating this medical necessity. Should you require any further information, please contact my office directly.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[License Number/NPI]