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

[Date]

To: [Name of Recipient/Property Management/Employer/School]
[Organization Name]
[Address]
[City, State, Zip Code]

Subject: Medical Necessity for Elevator Access - [Patient Name]

To Whom It May Concern,

I am the treating physician for [Patient Name], born on [Date of Birth]. [Patient Name] is currently under my care for a medical condition that significantly limits their physical mobility.

Due to this medical condition, the patient is unable to use stairs safely. Climbing or descending stairs poses a risk of [injury/falling/exacerbating the condition]. As a result, it is medically necessary for [Patient Name] to have unrestricted access to an elevator to move between floors within your facility.

I am requesting a formal medical accommodation to grant [Patient Name] elevator access effective immediately. This accommodation should remain in place [permanently / until Date].

If you require any further documentation or have questions regarding this medical necessity, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical License Number]