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

To Whom It May Concern,

RE: Temporary Hearing Support for [Patient Full Name]
Date of Birth: [DOB]

This letter is to certify that [Patient Name] is currently under the care of [Clinician Name] at [Clinic Name] for a temporary hearing impairment. This condition is expected to last from [Start Date] until approximately [End Date].

Due to this temporary condition, the patient requires the following accommodations to ensure effective communication and safety:

- Preferential seating close to the speaker.
- Written instructions for all verbal communications.
- Reduced background noise environment.
- Use of assistive listening devices or FM systems if available.
- [Additional Specific Requirement]

We request that you provide these temporary supports to assist the patient in their [educational/work/daily] environment during this recovery period.

If you have any questions or require further information, please contact our office at [Phone Number].

Sincerely,

[Signature of Physician/Audiologist]
[Printed Name and Title]
[Medical License Number]