**Date:** [Insert Date]

**To:** [Recipient Name/Organization Name]
**From:** [Physician/Provider Name]
**Subject:** Special Needs Accommodation Clearance

Dear [Recipient Name],

I am writing to provide medical clearance and support for the requested accommodations for my patient, [Patient Full Name], born on [Patient Date of Birth].

Based on my clinical evaluation and the patient's medical history, [Patient Name] has a diagnosed condition that necessitates specific accommodations to ensure their health, safety, and equal participation in [School/Work/Activity].

**Required Accommodations:**

- [Accommodation 1: e.g., Wheelchair accessibility/ramps]
- [Accommodation 2: e.g., Extended time for tasks or testing]
- [Accommodation 3: e.g., Frequent breaks for medication or rest]
- [Accommodation 4: e.g., Assistance with physical mobility]

I certify that these accommodations are medically necessary. These adjustments will allow the patient to function effectively without compromising their well-being. This clearance is valid from [Start Date] until [End Date/Ongoing].

If you require any further information or clarification regarding these medical requirements, please contact my office at [Phone Number].

Sincerely,

[Signature]

[Printed Name of Professional]
[Title/Credentials]
[Medical License Number]
[Clinic/Hospital Name]