[Physician Name]
[Medical Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

Social Security Administration
[Local Office Address]
[City, State, Zip Code]

RE: [Patient Name]
DOB: [Patient Date of Birth]
SSN: [Patient Social Security Number]

To Whom It May Concern:

I am writing this letter in support of [Patient Name]'s application for Social Security Disability Insurance (SSDI) benefits. I have been [Patient Name]'s primary care physician since [Date] and have treated them for the following diagnosed conditions:

- [Diagnosis 1 - include ICD-10 code if available]
- [Diagnosis 2]
- [Diagnosis 3]

[Patient Name] suffers from significant clinical symptoms, including [List symptoms such as chronic pain, fatigue, cognitive impairment, etc.]. These symptoms are documented in clinical findings such as [List objective tests like MRIs, X-rays, Blood Work, or Mental Status Exams].

Due to these conditions, [Patient Name] faces the following functional limitations:

- **Physical:** Can sit for only [Number] minutes and stand/walk for [Number] minutes at a time. Can lift no more than [Number] pounds.
- **Exertional:** Requires unscheduled breaks every [Number] hours due to [Reason].
- **Cognitive/Mental:** Struggles with concentration, following multi-step instructions, and interacting with others in a work setting.

In my professional medical opinion, [Patient Name]'s conditions are permanent or expected to last at least 12 months. Their limitations are severe enough to prevent them from maintaining any form of gainful employment, including sedentary work.

Please contact my office if you require further medical records or clarification regarding this patient's status.

Sincerely,

[Signature]
[Physician Name, MD/DO]