

[Physician Name, MD/DO]
[Medical Facility Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

RE: Social Security Disability Insurance (SSDI) Medical Support Letter

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

SSN (Last 4 digits): [Optional: XXX-XX-0000]

To Whom It May Concern,

I am a board-certified [Specialty Name] and have been the treating physician for [Patient Name] since [Date Treatment Started]. The patient is currently diagnosed with the following medically determinable impairments:

- [Primary Diagnosis Code and Description]
- [Secondary Diagnosis Code and Description]

Clinical Findings and Symptoms:

These diagnoses are supported by clinical evidence including [List tests: MRI, X-ray, Lab work, etc.]. The patient consistently presents with [List symptoms: chronic pain, fatigue, cognitive deficits, loss of range of motion, etc.].

Functional Limitations:

Due to these conditions, [Patient Name] experiences the following functional limitations in a work setting:

- Ability to sit for only [Number] minutes at a time.
- Ability to stand/walk for only [Number] minutes at a time.
- Requirement to elevate legs or rest frequently during the day.
- Limitations in [reaching, handling, fingering, or lifting weights over X lbs].
- Difficulty with [concentration, following instructions, or social interaction].

Treatment and Prognosis:

The patient has undergone [list treatments: medications, physical therapy, surgeries] with [minimal/moderate] success. Despite compliance with all prescribed treatments, the patient remains unable to perform sustained work activity on a regular and continuing basis (8 hours a day, 5 days a week). These limitations have lasted, or are expected to last, for at least 12 consecutive months.

Conclusion:

In my professional medical opinion, [Patient Name]'s physical and/or mental impairments are of

such severity that they prevent the patient from performing any past relevant work or any other form of gainful employment.

Sincerely,

[Signature]

[Physician Name, Title]

[Medical License Number]