[Date]

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

RE: Functional Capacity Evaluation and Support for Disability Claim

Claimant Name: [Patient Full Name]
Date of Birth: [DOB]
SSN: [Last 4 Digits of SSN]

To Whom It May Concern:

I am a licensed Physical Therapist at [Clinic Name] and have been treating [Patient Name] since [Start Date] for the following diagnoses: [List Medical Diagnoses/ICD-10 Codes].

Based on my clinical evaluations, objective testing, and the patient's response to therapeutic intervention, I have determined the following functional limitations regarding the patient's ability to perform work-related activities:

1. Lifting and Carrying: [Example: Patient is limited to lifting no more than 5 lbs occasionally due to severe lumbar instability].

2. Standing and Walking: [Example: Patient can stand for no more than 15 minutes at a time and requires a mobility aid for distances over 50 feet].

3. Sitting: [Example: Patient requires the ability to shift positions or lie down every 30 minutes due to chronic pain].

4. Postural Limitations: [Example: Patient is unable to stoop, kneel, crouch, or climb stairs safely].

5. Upper Extremity Function: [Example: Patient has significant deficits in reaching, handling, and fingering bilaterally].

In my professional opinion, these impairments are supported by objective findings including [List findings: e.g., reduced range of motion, muscle atrophy, positive special tests, or gait abnormalities]. The patient's functional deficits are expected to last for a continuous period of at least 12 months.

The patient's physical limitations are of such severity that they would prevent the performance of even sedentary work on a full-time, sustained basis. Please see the attached clinical notes and Functional Capacity Evaluation (FCE) results for further detail.

Sincerely,

[Signature]
[Printed Name, PT/DPT]
[License Number]
[Clinic Name]
[Phone Number]