

**[Date]**

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

**RE: [Patient's Full Name]**  
**Date of Birth: [Patient's DOB]**  
**SSN: [Patient's SSN]**

To Whom It May Concern:

I am writing this letter in support of **[Patient's Name]**'s application for Social Security Disability Insurance (SSDI). I have been **[Patient's Name]**'s treating physician since **[Date/Year]**, specializing in **[Your Specialty, e.g., Pain Management/Rheumatology]**.

**Diagnosis:**

The patient has been diagnosed with the following chronic conditions:

- [Condition 1, e.g., Degenerative Disc Disease]
- [Condition 2, e.g., Fibromyalgia]
- [Condition 3, e.g., Failed Back Surgery Syndrome]

**Clinical Findings and Symptoms:**

**[Patient's Name]** suffers from persistent, severe pain located in the **[specify body parts]**. Clinical objective findings include **[mention MRIs, X-rays, EMG results, or physical exam findings like reduced range of motion or muscle atrophy]**. Despite adhering to a treatment regimen including **[medications, physical therapy, injections]**, the patient remains significantly symptomatic.

**Functional Limitations:**

Due to the severity of their chronic pain and the side effects of prescribed medications (such as **[list side effects like drowsiness or cognitive fog]**), the patient is unable to perform sustained work activity. Specifically, the patient is limited in the following ways:

- Ability to sit: Limited to **[Number]** minutes at a time.
- Ability to stand/walk: Limited to **[Number]** minutes at a time.
- Lifting/Carrying: Cannot lift more than **[Number]** pounds.
- Need for breaks: Requires unscheduled rest periods of **[Duration]** throughout the day.

**Professional Opinion:**

In my professional medical opinion, **[Patient's Name]**'s impairments have lasted or are expected to last for at least 12 months. Their functional limitations make it impossible for them to maintain gainful employment in any capacity. I highly recommend that their claim for disability benefits be approved.

Please feel free to contact my office at **[Phone Number]** if you require further medical records or clarification.

Sincerely,

**[Physician Signature]**

[Physician Printed Name]

[Medical License Number]

[Clinic/Hospital Name]