

[Psychiatrist's Name, MD/DO]
[Clinic/Facility Name]
[Address]
[Phone Number]
[Date]

Social Security Administration
[Local Office Address]

RE: [Patient Name]
Date of Birth: [Patient DOB]
SSN: [Patient SSN]

To Whom It May Concern:

I am the treating psychiatrist for [Patient Name]. I have been treating this patient since [Start Date] for the following DSM-5 diagnosed conditions: [List Diagnoses, e.g., Major Depressive Disorder, Bipolar I, Schizoaffective Disorder]. The patient's current Global Assessment of Functioning or clinical severity is [Detail Severity].

The patient exhibits the following symptoms: [List Symptoms, e.g., psychomotor retardation, cognitive impairment, hallucinations, social withdrawal, or manic episodes]. Despite compliance with [List Medications/Therapies], the patient remains significantly symptomatic.

In my professional medical opinion, [Patient Name] has "Marked" or "Extreme" limitations in the following functional areas:

- **Understand, remember, or apply information:** [Describe deficits in following instructions].
- **Interact with others:** [Describe inability to sustain social interactions or handle conflict].
- **Concentrate, persist, or maintain pace:** [Describe inability to complete tasks timely or maintain focus].
- **Adapt or manage oneself:** [Describe inability to handle change or maintain personal hygiene/safety].

Due to these psychiatric impairments, the patient is unable to sustain any form of gainful employment. These limitations have lasted, or are expected to last, for a continuous period of at least 12 months. The patient is unable to function in a workplace environment even with simple, repetitive tasks.

Please contact my office if further clinical documentation or treatment records are required.

Sincerely,

[Signature]

[Psychiatrist's Printed Name]

[Medical License Number]