

[Date]

Social Security Administration

[Local Office Address]

[City, State, Zip Code]

RE: Residual Functional Capacity Statement for [Claimant's Full Name]

SSN: [Claimant's Social Security Number]

To Whom It May Concern:

I am writing this letter in support of the disability claim for [Claimant's Name]. I am a [Your Medical Title/Specialty] and have been treating the claimant since [Date of First Visit]. I see the claimant every [Frequency of Visits] for the following diagnosed conditions: [List Diagnoses].

Based on my clinical findings, objective testing, and the claimant's medical history, it is my professional opinion that [Claimant's Name] possesses the following functional limitations:

**Exertional Limitations:**

The claimant can sit for [Number] hours and stand/walk for [Number] hours in an 8-hour workday. They can lift/carry a maximum of [Number] pounds occasionally and [Number] pounds frequently.

**Postural and Manipulative Limitations:**

The claimant is limited in their ability to [e.g., stoop, crouch, reach, or handle objects] due to [Medical Reason]. Specifically, they can perform these actions for only [Percentage/Time] of the workday.

**Non-Exertional and Mental Limitations:**

The claimant experiences [e.g., fatigue, cognitive fog, anxiety, or pain] that interferes with their concentration and pace. I estimate they would be "off-task" for [Percentage] of a standard workday and would likely miss [Number] days of work per month due to their impairments.

**Clinical Basis:**

These limitations are supported by [e.g., MRI results, X-rays, clinical observations, or range of motion testing] conducted on [Date].

In summary, [Claimant's Name] is unable to perform sustained full-time work on a regular and continuing basis due to the severity of their physical and/or mental restrictions.

Sincerely,

[Your Signature]

[Your Printed Name]

**[Medical Facility Name]**  
**[Phone Number]**