[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

RE: Disability Extension Request for [Patient Name]
Date of Birth: [Patient Date of Birth]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

I am the attending physician for [Patient Name]. I am writing to provide medical documentation to support an extension of [his/her/their] disability period.

[Patient Name] has been under my care for the following diagnosis: [Diagnosis Name/ICD Code]. Due to the nature of this condition, the patient continues to experience [brief list of symptoms or functional limitations] which prevent them from performing the essential duties of their occupation.

The patient was originally scheduled to return to work on [Original Date]. However, based on my most recent evaluation on [Date of Last Exam], it is my medical opinion that the patient requires additional recovery time.

I am extending the period of total disability from [Original End Date] to [New Estimated Return Date].

The treatment plan during this extension includes [e.g., physical therapy, medication adjustment, specialist referral]. I will re-evaluate the patient's status on [Follow-up Appointment Date] to determine if they can return to work at that time, with or without restrictions.

If you require additional information or medical records, please contact my office.

Sincerely,

[Signature of Physician]
[Printed Name of Physician]
[Medical License Number]
[Board Certification]