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

Date: [Date]

To Whom It May Concern,

I am the treating physician for [Patient Full Name], born on [Date of Birth]. [Patient Name] has been under my care since [Date] for the management of [Name of Chronic Condition(s)].

This letter is to certify that my patient is currently experiencing an acute exacerbation (flare-up) of their chronic condition. During these periods of exacerbation, the patient experiences severe symptoms, including [List primary symptoms, e.g., extreme fatigue, chronic pain, cognitive impairment, or mobility issues].

Due to this medical setback, [Patient Name] is currently unable to perform the essential duties of their [Job/School] responsibilities. These symptoms significantly limit the patient's major life activities and necessitate the following restrictions:

- [Restriction 1, e.g., Complete bed rest or reduced hours]
- [Restriction 2, e.g., Frequent breaks or modified physical activity]
- [Restriction 3, e.g., Use of assistive devices or remote work options]

I anticipate that this period of increased disability will last from [Start Date] until approximately [Estimated End Date], at which time we will re-evaluate their status.

Please provide [Patient Name] with all necessary accommodations and considerations required under the Americans with Disabilities Act (ADA) or applicable local regulations to support their recovery and health management.

If you require further clinical documentation or have questions regarding these restrictions, please contact my office directly.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]