Date: [Date]

To: [Insurance Company Name or Employer Name]
Re: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Claim Number (if applicable): [Claim Number]

To Whom It May Concern,

I am writing to provide medical documentation for [Patient Name] regarding their application for short-term disability benefits. [Patient Name] is currently under my care for the management of a cardiac condition.

Diagnosis: [Insert Diagnosis, e.g., Myocardial Infarction, Congestive Heart Failure, Post-CABG]

Procedure Performed: [Insert Procedure Name or N/A]
Date of Procedure: [Date]

Due to the nature of this cardiac condition and the physical demands of recovery, the patient is unable to perform their professional duties at this time. The patient is restricted from [List restrictions, e.g., heavy lifting, prolonged standing, high-stress environments] to prevent further cardiac complications.

Disability Period:
The patient has been unable to work since [Start Date]. At this time, I anticipate the patient will remain disabled and require recovery time until [Estimated Return to Work Date].

The patient will be re-evaluated on [Follow-up Appointment Date]. At that time, we will determine if a return to work with or without restrictions is appropriate.

If you require any additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Medical License Number]