

[Physician Name, MD/DO]

[Clinic Name]

[Clinic Address]

[Phone Number]

[Date]

RE: [Patient Full Name]

DOB: [Patient Date of Birth]

Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

I am the primary care physician for [Patient Name], who has been under my care since [Start Date]. This letter is to provide medical clinical findings regarding [Patient Name]'s functional limitations and their inability to perform the duties of [his/her/their] occupation.

Diagnosis:

[Patient Name] is currently being treated for the following conditions: [List Diagnoses, including ICD-10 codes].

Clinical Findings and Symptoms:

The patient exhibits the following symptoms: [List symptoms, e.g., chronic pain, cognitive fatigue, reduced range of motion]. These symptoms are supported by [List objective evidence, e.g., MRI results, laboratory tests, physical exams dated XX/XX/XXXX].

Functional Limitations:

Due to these conditions, [Patient Name] is restricted in the following ways:

- **Physical:** [e.g., Cannot sit or stand for more than 20 minutes; limited to lifting no more than 5 lbs].
- **Cognitive:** [e.g., Impaired concentration and memory; unable to handle complex tasks for extended periods].
- **Environmental:** [e.g., Must avoid high-stress environments or loud noises].

Conclusion:

In my professional medical opinion, [Patient Name] is currently unable to perform the material and substantial duties of [his/her/their] regular occupation or any occupation for which [he/she/they] is reasonably qualified by education, training, or experience. These restrictions are expected to last for [Expected Duration].

Please contact my office if you require further documentation or clarification.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical License Number]