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

Date: [Current Date]

RE: Disability Claim Support for [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Claim Number: [Claim Number, if known]

To Whom It May Concern,

I am a board-certified [Your Specialty] and have been the treating physician for [Patient Name] since [Date Treatment Began]. I am writing this letter to document the patient's medical condition and the resulting functional limitations that impact their ability to maintain gainful employment.

Diagnosis:
The patient has been diagnosed with the following conditions: [List primary and secondary diagnoses with ICD-10 codes]. These diagnoses are confirmed by objective medical evidence, including [List tests: MRI, X-ray, Labs, Biopsy, etc.].

Clinical Findings and Symptoms:
The patient's symptoms include [List symptoms: e.g., chronic pain, cognitive impairment, fatigue, reduced range of motion]. Upon physical examination, the patient demonstrates [List objective findings: e.g., muscle weakness, neurological deficits, sensory loss].

Functional Limitations:
Due to the severity of these conditions, the patient is restricted in the following ways:

- [Example: Cannot sit for more than 20 minutes at a time.]
- [Example: Cannot lift or carry more than 5 pounds.]
- [Example: Significant deficits in concentration and pace due to medication side effects/pain.]
- [Example: Requires frequent unscheduled breaks for rest or treatment.]

Medical Opinion:
In my professional medical opinion, [Patient Name]'s condition is chronic and expected to last [Duration or "indefinitely"]. These limitations prevent the patient from performing the essential duties of their previous occupation or any other sustained full-time work. The patient's condition is not expected to improve significantly enough to allow for a return to the workforce in the foreseeable future.

Please contact my office at [Phone Number] if you require further documentation or have additional questions.

Sincerely,

[Signature]

[Typed Physician Name]
[Medical License Number]