

[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

To Whom It May Concern:

RE: [Patient Full Name]

Date of Birth: [DOB]

I am writing this letter in support of [Patient Name]'s application for disability benefits. I am a [Job Title, e.g., Licensed Clinical Social Worker / Psychiatrist] at [Clinic Name], and I have been treating [Patient Name] since [Start Date of Treatment].

Diagnosis:

The patient has been diagnosed with the following mental health condition(s) according to the DSM-5 criteria:

- [Primary Diagnosis and ICD-10 Code]
- [Secondary Diagnosis, if applicable]

Clinical Symptoms and History:

[Patient Name] presents with symptoms including [List symptoms, e.g., severe panic attacks, cognitive impairment, depressive episodes, social withdrawal]. These symptoms are persistent despite [List treatments, e.g., medication management, weekly psychotherapy].

Functional Limitations:

Due to their mental health condition, the patient experiences significant limitations in the following areas:

- **Concentration:** Difficulty maintaining focus on simple tasks for more than [Time Frame].
- **Social Interaction:** Inability to interact appropriately with supervisors, coworkers, or the public.
- **Adaptation:** Inability to manage changes in a work environment or handle workplace stress.
- **Daily Living:** [List limitations, e.g., difficulty with self-care or managing a schedule].

Professional Opinion:

In my professional opinion, [Patient Name]'s impairments are of such severity that they are unable to sustain gainful employment at this time. These limitations are expected to last for a period of [Expected Duration, e.g., 12 months or longer].

Please contact my office if you require further documentation or clinical records regarding this case.

Sincerely,

[Signature]

[Printed Name and Credentials]

[License Number]

[Clinic Name]