[Physician Name/Clinic Name]
[Medical License Number]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email]

[Date]

RE: Medical Verification for [Patient Full Name]
Date of Birth: [DOB]

To Whom It May Concern,

I am the treating physician for [Patient Name], who has been under my care since [Date]. This letter serves to verify that [Patient Name] has been diagnosed with the following neurological condition: [Diagnosis/ICD-10 Code].

This condition is characterized by [List primary symptoms, e.g., cognitive impairment, motor dysfunction, seizures, chronic pain, or sensory deficits]. Due to the nature of this neurological disorder, the patient experiences significant functional limitations in the following areas:

- [Functional Limitation 1]
- [Functional Limitation 2]
- [Functional Limitation 3]

The patient's symptoms are [permanent / progressive / intermittent] and require ongoing medical management, including [list treatments, medications, or therapy if applicable]. As a result of these medical constraints, I recommend the following accommodations/supports: [List specific recommendations, e.g., workplace adjustments, mobility aids, or academic extensions].

Please contact my office at [Phone Number] if you require further documentation or clarification regarding [Patient Name]'s medical status.

Sincerely,

[Signature]

[Printed Name and Title]