

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

[Date]

RE: Verification of Permanent Disability Status

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Medical Record Number: [MRN]

To Whom It May Concern,

This letter serves as official verification from [Clinic Name] regarding the medical status of the above-named patient. [Patient Name] is currently under the care of [Physician Name] at our facility.

Based on a comprehensive review of the patient's medical records and clinical evaluations, it has been determined that the patient has a permanent physical or mental impairment that substantially limits one or more major life activities. This condition is chronic and is not expected to improve significantly in the foreseeable future.

Due to this permanent disability, the patient requires the following accommodations or support:
[List accommodations or "N/A"]

This information is provided at the request of the patient for the purpose of [State Purpose, e.g., housing, transportation, or social services].

Should you require any further information or clarification, please contact our administrative office at [Phone Number].

Sincerely,

[Signature]
[Name of Clinic Administrator]
[Title]
[Clinic Name]