[Physician Name, MD/DO/Specialist Title]
[Medical Facility Name]
[Address]
[Phone Number]
[Date]

RE: Total and Permanent Disability Determination
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/SSN: [Reference Number]

To Whom It May Concern,

I am writing to provide a clinical evaluation regarding the physical/mental status of [Patient Name]. I am a board-certified specialist in [Specialty] and have been treating the patient for [Duration of Time] for the following diagnosed conditions: [List Primary Diagnoses].

Based on my clinical findings, diagnostic testing, and the patient's medical history, it is my professional opinion that [Patient Name] suffers from a total and permanent disability as defined by the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment.

Clinical Basis for Determination:

- **Nature of Impairment:** [Describe chronic nature of the condition]
- **Functional Limitations:** [Detail specific limitations, e.g., mobility, cognitive function, lifting, sitting, or concentration]
- **Treatment History:** [Briefly mention failed treatments or management strategies]
- **Prognosis:** [State that the condition is expected to result in death or has lasted/is expected to last for a continuous period of not less than 12 months]

The patient's condition is stable but non-reversible. The impairments listed above prevent the patient from performing the duties of any occupation for which they are qualified by education, training, or experience. There is no expectation of significant medical improvement in the foreseeable future.

I certify that the information provided is based on medical records and personal examinations of the patient.

Sincerely,

[Signature]

[Printed Name]
[Medical License Number]
[State of Licensure]