

[Date]

[Provider Name, Degree]

[Clinic/Hospital Name]

[Address]

[City, State, Zip Code]

[Phone Number]

To: U.S. Department of Education / Total and Permanent Disability (TPD) Discharge Servicer

RE: Medical Assessment for [Patient Name]

Date of Birth: [Patient DOB]

Last 4 Digits of SSN: [Optional/Last 4]

To Whom It May Concern,

I am the primary care provider for [Patient Name]. I am writing to certify that this patient has a medically determinable physical or mental impairment that prevents them from engaging in any substantial gainful activity.

1. Diagnosis:

The patient has been diagnosed with the following condition(s): [List primary diagnoses].

2. Severity and Duration:

The patient's condition is of such severity that they are unable to work or earn money in any capacity. This impairment:

- Has lasted for a continuous period of at least 60 months; OR
- Can be expected to last for a continuous period of at least 60 months; OR
- Can be expected to result in death.

3. Clinical Basis:

This assessment is based on [mention briefly: e.g., clinical examinations, laboratory findings, specialist consultations, and history of treatment]. Due to [specific functional limitations, e.g., cognitive deficits, physical mobility restrictions], the patient cannot perform the duties of any occupation available in the national economy.

I certify that I am a [Physician (MD/DO) / Nurse Practitioner / Physician Assistant / Psychologist] licensed to practice in the State of [State] and that the information provided is true and correct to the best of my medical knowledge.

Sincerely,

[Signature]

[Printed Name]

[State License Number]

[NPI Number]