[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Recipient Name/Organization]
[Department]
[Address]
[City, State, Zip Code]

RE: Extension of Disability Certification for [Patient Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I am writing to provide an updated certification regarding the medical condition and disability status of my patient, [Patient Name].

[Patient Name] has been under my care for [Condition/Diagnosis] since [Date]. Due to the ongoing nature of this condition, the patient continues to experience limitations that affect their ability to perform [specific tasks/work duties].

Based on my most recent evaluation on [Date of Last Exam], it is my medical opinion that the current disability period should be extended. The previous certification was set to expire on [Previous End Date]; however, I am recommending an extension until [New Estimated End Date or "Indefinite"].

During this extended period, the following restrictions remain in place:
[List specific restrictions or "All previous restrictions apply"].

We will continue to monitor [Patient Name]'s progress and will provide further updates as necessary. Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Signature]

[Physician Printed Name]
[Medical License Number]