[Physician Name/Medical Practice Name]
[Address Line 1]
[Address Line 2]
[Phone Number]
[Date]

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

To Whom It May Concern,

I am the treating physician for [Patient Name]. This letter is to certify that [Patient Name] has been diagnosed with the following chronic medical condition(s):

- [Diagnosis 1]
- [Diagnosis 2]

Due to the nature of these chronic conditions, the patient experiences significant functional limitations, including but not limited to:

- [Description of limitation, e.g., inability to stand for more than 15 minutes]
- [Description of limitation, e.g., severe chronic fatigue affecting cognitive function]
- [Description of limitation, e.g., restricted mobility or chronic pain]

These impairments are long-term in nature and substantially limit the patient's ability to perform major life activities and/or work-related tasks. It is my professional medical opinion that [Patient Name] meets the criteria for disability under [applicable law/policy, e.g., the Americans with Disabilities Act].

The patient is currently under a treatment plan consisting of [medication/therapy/specialized care]. Despite these interventions, the limitations described above remain persistent.

Please contact my office at [Phone Number] if you require further documentation or clinical records regarding this certification.

Sincerely,

[Signature of Physician]
[Printed Name of Physician]
[Medical License Number]
[Board Certification]