[Physician Name/Medical Facility Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To Whom It May Concern,

This letter serves to certify that [Patient Name] (DOB: [Date of Birth]) is currently under my medical care for a documented health condition.

Based on my clinical evaluation and the patient's medical history, I have determined that [Patient Name] is experiencing a **partial disability**. This condition significantly limits the patient's ability to perform certain tasks, but does not result in total incapacity.

Clinical Status:
The patient is currently restricted in the following areas:
[List specific physical or cognitive limitations, e.g., lifting restrictions, reduced standing time, or limited work hours].

Duration:
The patient's partial disability began on [Start Date]. At this time, the expected duration of these limitations is:
[Select one: Permanent / Temporary until (Date) / Indefinite pending further evaluation].

Recommended Accommodations (if applicable):
To maintain the patient's health and safety, I recommend the following accommodations:
[List specific accommodations or work modifications].

Please feel free to contact my office if you require additional information or further clarification regarding this certification.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]
[Board Certification]