Date: [Insert Date]

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert DOB]
Claim/Reference Number: [Insert Number]

To Whom It May Concern,

I am writing to provide the formal disability evaluation for the above-named patient, who has been under my medical care since [Start Date].

Diagnosis:
The patient has been diagnosed with [Insert Medical Condition/ICD Code]. This condition is the result of [Injury/Illness] which occurred on [Date].

Clinical Findings:
Based on clinical examinations, diagnostic testing, and functional assessments, the patient exhibits the following symptoms and limitations: [List major symptoms and physical/mental limitations].

Permanent Impairment Status:
It is my professional medical opinion that the patient has reached Maximum Medical Improvement (MMI). Further medical treatment is not expected to result in significant functional improvement. Therefore, the patient's impairment is considered permanent.

Functional Restrictions:
Due to the permanent nature of this disability, the patient is restricted from the following activities:

- [Restriction 1, e.g., Lifting more than 10 lbs]
- [Restriction 2, e.g., Prolonged standing or walking]
- [Restriction 3, e.g., Repetitive overhead reaching]

Conclusion:
The patient is [totally/partially] disabled and is unable to perform the essential duties of their previous occupation. The estimated whole-body impairment rating is [Insert Percentage]%.

Please contact my office if you require further documentation or clarification.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]
[Phone Number]