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

[Date]

To [Name of Employer/School/Landlord]:

Re: Accommodation Request for [Patient Name]

To Whom It May Concern,

I am the treating [Physician/Provider Type] for [Patient Name]. [Patient Name] has a medical condition that qualifies as a disability under the [Americans with Disabilities Act (ADA) / relevant local law].

This condition results in functional limitations that impact the patient's ability to perform the following tasks:
- [List functional limitation, e.g., standing for long periods]
- [List functional limitation, e.g., lifting more than 10 lbs]

To assist the patient in performing their [job duties/educational requirements/daily living activities], I recommend the following reasonable accommodations:
- [Specific Accommodation 1]
- [Specific Accommodation 2]

These accommodations are medically necessary to [reason, e.g., reduce pain, prevent further injury, allow equal access]. This request is expected to be [permanent / temporary until DATE].

Please contact my office if you require any further clarification regarding these medical recommendations.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]