Date: [Insert Date]

To: [Employer Name/Human Resources Department]
Company: [Company Name]
Address: [Company Address]

RE: Medical Necessity for Ergonomic Accommodation
Patient Name: [Patient Name]
Date of Birth: [Patient DOB]

To Whom It May Concern,

I am the treating physician for [Patient Name]. Due to a diagnosed medical condition, this patient requires specific ergonomic workplace accommodations to perform their essential job functions safely and to prevent further injury or exacerbation of symptoms.

I am prescribing the following ergonomic equipment for their workstation:

- **[Item 1, e.g., Height-Adjustable Sit-Stand Desk]:** To allow for frequent position changes and reduce prolonged spinal loading.
- **[Item 2, e.g., Ergonomic Task Chair]:** Must include adjustable lumbar support, seat depth, and armrests to maintain neutral posture.
- **[Item 3, e.g., Vertical Mouse/Ergonomic Keyboard]:** To reduce repetitive strain and maintain neutral wrist alignment.
- **[Item 4, e.g., Monitor Arm]:** To ensure the screen is at eye level and prevent neck strain.

The duration of this medical necessity is expected to be [Permanent / Duration in Months]. Please implement these accommodations as soon as possible to ensure the patient's health and continued productivity.

If you require further clarification regarding these medical requirements, please contact my office at [Phone Number].

Sincerely,

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