

**Date:** [Insert Date]

**To:** [Employer Name / Human Resources Department]

**Company:** [Company Name]

**Address:** [Company Address]

**RE: Medical Authorization for Remote Work Accommodation**

To Whom It May Concern,

I am the treating [Physician/Provider Title] for [Employee Name], who is currently under my medical care. [Employee Name] has a medical condition that meets the criteria for a disability under the Americans with Disabilities Act (ADA) or applicable local disability laws.

Due to this condition, the patient has functional limitations that impact their ability to work in a traditional office environment. These limitations include: [Optional: Briefly describe limitations, e.g., compromised immune system, mobility issues, or sensory triggers].

As a medical necessity, I am prescribing a remote work (work-from-home) accommodation. This accommodation will allow the patient to perform their essential job functions while managing their health condition effectively. I recommend this accommodation be implemented:

- Permanently
- Temporarily until [Insert Date]
- On a hybrid basis ([Number] days per week)

This accommodation is required to prevent further exacerbation of the patient's condition and to ensure their health and safety. Please let me know if you require any further clarification regarding these medical restrictions.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO/NP/PA]**

[Medical License Number]

[Clinic/Practice Name]

[Phone Number]

[Email Address]