Date: [Insert Date]

To: [Recipient Name/Organization Name]
From: [Physician Name and Credentials]
Subject: Medical Necessity and Prescription for Mobility Device Accommodation

To Whom It May Concern,

I am the primary care physician for [Patient Name], born on [Patient Date of Birth]. My patient is currently under my care for a medical condition that significantly impairs their physical mobility and ability to ambulate independently.

Due to this condition, I have prescribed the following mobility device for daily use: **[Specific Device: e.g., Manual Wheelchair, Power Scooter, Walker]**. This device is medically necessary to ensure the patient's safety, stability, and functional independence.

I am requesting a formal medical accommodation for [Patient Name] to use this device in the following capacity: [Insert specific request, e.g., in the workplace, during travel, or within the housing facility]. This accommodation is essential for the patient to perform essential tasks and mitigate the risk of injury or physical exhaustion.

The patient requires this accommodation for the following duration: [e.g., Permanent, or specify end date].

Should you require any further documentation or have questions regarding this prescription, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic/Hospital Name]
[Contact Information]