Date: [Insert Date]

To: [Employer Name / Academic Institution / Disability Services]

From: [Physician/Provider Name, Credentials]

Subject: Medical Authorization for Visual Aid Accommodation

To Whom It May Concern,

I am the treating [Physician/Specialist] for **[Patient Name]** (DOB: [Date of Birth]). [Patient Name] is under my care for a diagnosed visual impairment that substantially limits their ability to perform tasks requiring visual acuity and sustained eye strain.

To mitigate the impact of this condition and allow the patient to perform their essential duties effectively, I am prescribing the following medical accommodations:

- **Prescription Visual Aids:** Use of [Specific Device, e.g., handheld magnifier, electronic video enhancer, or prescription high-power lenses].
- **Software Requirements:** Use of screen-reading software, text-to-speech tools, or screen magnification software.
- **Environmental Adjustments:** [e.g., High-contrast keyboard, anti-glare screen filters, or specialized task lighting].
- **Operational Adjustments:** Frequent "eye breaks" (e.g., 5 minutes every hour) to reduce ocular fatigue.

These aids are medically necessary for [Patient Name] to access information and complete tasks safely and efficiently. These accommodations should be implemented as soon as possible.

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

Sincerely,

[Signature]
[Printed Name]
[Medical License Number]
[Clinic/Hospital Name]