

**Date:** [Date]

**To:** [Employer Name / HR Department]

**Company:** [Company Name]

**Address:** [Company Address]

**RE: Medical Authorization for Reduced Work Hours**

**Employee Name:** [Employee Full Name]

**Date of Birth:** [Employee DOB]

To Whom It May Concern,

I am the treating physician for [Employee Name]. Due to a documented medical condition, it is my professional medical recommendation that this patient receive a temporary modification to their work schedule as a necessary medical accommodation.

**Prescribed Restrictions:**

- The patient is restricted to working no more than [Number] hours per day.
- The patient is restricted to working no more than [Number] hours per week.
- [Optional: Specific shift restrictions, e.g., No night shifts or required break intervals].

**Duration:**

These restrictions are effective immediately as of [Start Date] and are expected to remain in place until [End Date/Follow-up Evaluation Date].

This accommodation is medically necessary to allow the patient to continue performing their essential job functions while managing their health condition. Please contact my office at [Phone Number] if you require further clarification regarding these medical limitations.

Sincerely,

[Physician Signature]

**Physician Name:** [Name and Title]

**Medical License #:** [License Number]

**Clinic/Facility Name:** [Clinic Name]