

**Date:** [Insert Date]

**To:** [Recipient Name/Employer Name/Academic Institution]

**From:** [Physician Name, Credential]

**Subject:** Prescription Authorization for Medical Accommodation: Therapeutic Rest

To Whom It May Concern,

I am the treating physician for [Patient Name], born on [Patient Date of Birth]. Due to a diagnosed medical condition, it is my clinical recommendation that [Patient Name] be granted specific workplace/academic accommodations to manage their symptoms and support their ongoing treatment plan.

I am prescribing a medical accommodation for **Therapeutic Rest**. This requirement is a medical necessity to prevent the exacerbation of symptoms and to maintain the patient's functional capacity.

**Accommodation Requirements:**

- **Rest Frequency:** [e.g., A 15-minute break every 2 hours of active work/study].
- **Environment:** [e.g., Access to a quiet, low-stimulation area or the ability to recline].
- **Duration:** [e.g., These accommodations are required for the next 6 months / permanently].

During these periods of therapeutic rest, the patient must be relieved of all duties. This accommodation is designed to allow the patient to continue performing the essential functions of their role while managing their health safely.

Should you require further clarification regarding these medical limitations, please contact my office directly at [Phone Number]. Thank you for your cooperation in supporting this patient's health and productivity.

Sincerely,

[Signature]

[Physician Name, Degree]

[Medical License Number]

[Clinic/Hospital Name]

[Contact Information]