**Date:** [Insert Date]

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

**From:** [Physician Name, Degree]
[Clinic/Medical Facility Name]
[Phone Number]

**Subject: Medical Authorization for Specialized Footwear Accommodation**

**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient DOB]

To Whom It May Concern,

I am the treating physician for [Patient Name]. Due to a diagnosed medical condition affecting the patient's lower extremities, it is medically necessary for them to wear specialized footwear while performing their job duties.

The patient requires the following footwear specifications to manage their condition and prevent further injury:

- [Requirement: e.g., Orthopedic insoles/inserts]
- [Requirement: e.g., Wide toe box or extra depth]
- [Requirement: e.g., Specific arch support or slip-resistance]
- [Requirement: e.g., Non-standard safety toe materials]

Standard-issue footwear or strict adherence to specific uniform shoe requirements is currently contraindicated for this patient. I am prescribing the use of [Specific Brand/Type if applicable] or equivalent medical-grade footwear as a reasonable accommodation.

This medical necessity is expected to be: [Permanent / Temporary until Date].

If you require further clinical clarification regarding these functional limitations, please contact my office directly.

Sincerely,

[Physician Signature]

[Physician Name, Degree]
[Medical License Number]