MEDICAL LETTER OF RECOMMENDATION

Patient Name: _____ Date of Birth: _____

Physician Name: _____

Physician License Number: _____

Practice Address: _____

Contact Phone/Email: _____

Patient Medical Information and Recommendation:

This letter serves to confirm that the patient named above has been under my care for medical evaluation and treatment. After thorough examination and review of medical history, it is my professional opinion that the patient requires accommodations and support as outlined in this letter. The information provided herein is accurate to the best of my knowledge and consistent with the standards of medical practice under United States law.

Diagnosis and Clinical Findings:

The patient has been diagnosed with the following medical condition(s): _____. Clinical findings supporting this diagnosis include: _____. These findings substantiate the recommendations provided.

Recommended Accommodations and Restrictions:

In order to effectively manage the patient's condition and promote their health and well-being, the following accommodations or restrictions are recommended: _____. These recommendations should be implemented promptly and maintained for the duration deemed medically necessary.

Duration and Follow-up:

The recommendations contained in this letter are effective immediately and should remain in effect for a period appropriate to the patient's clinical status. Regular follow-up appointments are advised to monitor progress and adjust accommodations as medically indicated.

Confidentiality and Legal Compliance:

This letter contains confidential medical information protected under applicable federal and state laws, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Disclosure or use of this information is restricted to authorized individuals or entities. This document is intended to be legally compliant and enforceable under United States law.

Physician's Attestation:

I hereby certify that the information contained in this letter is truthful and accurate to the best of my professional knowledge and belief. This letter has been prepared following a comprehensive medical evaluation and is intended solely for the purposes stated herein.

PHYSICIAN'S SIGNATURE

Signature: _____

PATIENT'S ACKNOWLEDGEMENT

Signature: _____