

**Date:** [Date]

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Date of Birth]

**Patient ID/SSN:** [ID Number]

To Whom It May Concern,

I am the treating physician for [Patient Name], who has been under my care since [Date].

Based on my clinical evaluation and medical records, I am certifying that the patient is currently experiencing a physical or mental impairment that prevents them from performing the essential duties of their occupation. This disability is expected to be permanent, long-term, or of a duration lasting at least [Number] months.

**Diagnosis:** [Diagnosis Name/ICD-10 Code]

**Date of Disability Onset:** [Date]

**Expected Duration:** [Permanent / Estimated Return to Work Date]

Due to this condition, the patient has the following functional limitations: [List limitations, e.g., inability to sit for long periods, cognitive impairment, etc.].

In my professional medical opinion, [Patient Name] is unable to engage in substantial gainful activity and is eligible for disability income benefits.

Please contact my office at [Phone Number] if you require additional medical documentation or clarification.

Sincerely,

[Physician Signature]

**[Physician Printed Name]**

[Medical License Number]

[Practice Name/Clinic Name]

[Address]

[Phone Number]