Disability Verification Letter

Date: _____

To Whom It May Concern,

This letter is to verify that _____ is under my care as a licensed health professional. Based on my evaluation, the individual has a disability as defined by applicable federal and state laws.

Nature of Disability: _____
Duration/Expected Duration: _____
Impact on Major Life Activities: _____

If you need further information, please contact me.

Health Professionalâ€™s Name: _____
Title/License: _____
Signature: _____
Date: _____
Contact Information: _____