Name: ______________________________

Social Security Number: ______________________________

Doctor's name: ______________________________

Doctor's address: ______________________________

____

____

Doctor's phone number: ______________________________

Dear Social Security Claims Representative:

My patient, ____________________ requires the following item(s)/service(s) that enable him/her to work:

____

____

____.

I believe that without the item(s)/service(s) listed above, this individual could not sustain his/her work effort.

Please call me if you have any questions.

____

Signature

____

Date