

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]

[Date]
[Recipient Name]
[Recipient Title]
[Organization/Company]
[Address]

[City, State, Zip Code]

Subject: Medical Evidence for BGT Application

Dear [Recipient Name],

I am writing to provide the necessary medical evidence to support my application for [specific purpose, e.g., benefits, treatment, or assistance] related to my condition. Below, you will find relevant details regarding my medical history and current health status.

1. ****Patient Information****

- Full Name: [Your Full Name]
- Date of Birth: [Your Date of Birth]
- Medical Record Number: [Your Medical Record Number] (if applicable)

2. ****Medical Condition****

- Diagnosis: [Your Medical Diagnosis]
- Duration of Condition: [How long you have had the condition]
- Symptoms: [List of symptoms you are experiencing]

3. ****Treatment History****

- Name of Healthcare Providers: [List names and specialties of doctors/clinics]
- Treatment Received: [Outline treatments received, e.g., medications, surgeries]
- Current Treatment Plan: [Describe the current medical treatment plan]

4. ****Relevant Medical Documentation****

- Attached are copies of my medical records, including [mention any specific documents, e.g., lab results, prescriptions, letters from specialists].

5. ****Impact on Daily Life****

- [Briefly describe how the condition affects your daily activities and quality of life].

Please feel free to contact me if you require any further information or documentation. Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]