**To Whom It May Concern:**  Date.......................................

Re (patient name, address and DOB): ..........................................................................................

 ..........................................................................................

 ..........................................................................................

The patient named above is diagnosed with narcolepsy, which is a chronic condition that has no cure and causes significant impairment of functioning.

It is usually non-progressive but also does not improve with time.

Please accept this letter as proof of ongoing disability.

Yours faithfully Surgery stamp here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of signatory:

Valid for (please indicate):

5 years from above date

Indefinitely