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

[Date]

[Doctor's Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]

RE: Medical Documentation for Workers' Compensation Leave
Patient Name: [Your Full Name]
Date of Injury: [Date of Incident]
Claim Number: [Your Claim Number, if known]

Dear Dr. [Doctor's Last Name],

I am writing to formally request a medical status report and a work capacity evaluation regarding my recent work-related injury. As part of my Workers' Compensation claim, my employer requires specific documentation to authorize my medical leave of absence and potential disability benefits.

Please provide a letter or complete the attached forms addressing the following:

- A confirmation of my diagnosis and its relationship to the workplace incident.
- Your recommendation regarding my ability to work (e.g., total temporary disability or light-duty restrictions).
- The specific physical limitations I must follow (e.g., lifting limits, sitting/standing durations).
- The expected duration of my leave or the date of my next evaluation.

Please send the completed documentation to my attention or directly to my insurance adjuster, [Adjuster Name], at [Email/Fax Number].

Thank you for your time and assistance in this matter.

Sincerely,

[Your Signature]

[Your Printed Name]