Date: [Date]

To: [Employee Name]
Address: [Employee Address]
Claim Number: [Claim Number]

Subject: Notice of Termination of Workers' Compensation Benefits

Dear [Employee Name],

We are writing to inform you of a change regarding your workers' compensation benefits. Based on the medical report dated [Date of Medical Report] from [Physician Name], it has been determined that you have reached Maximum Medical Improvement (MMI).

Maximum Medical Improvement means that your condition has stabilized and no further functional improvement is expected, despite continued medical treatment. As a result of this medical determination, your temporary disability benefits will be terminated effective [Date of Termination].

The physician has provided the following assessment regarding your ability to work:

- **Work Status:** [e.g., Released to full duty / Released with permanent restrictions]
- **Impairment Rating:** [Percentage, if applicable]

If you have been assigned permanent work restrictions, we will review your job description to determine if a reasonable accommodation can be made. If you have been assigned a Permanent Partial Disability (PPD) rating, you will receive a separate notice regarding any additional benefits you may be entitled to receive.

If you disagree with this determination, you have the right to appeal this decision through the [State Workers' Compensation Board/Commission] within [Number] days of receiving this letter.

Please contact your claims adjuster, [Adjuster Name], at [Phone Number] if you have any questions regarding this notice.

Sincerely,

[Your Name/Company Representative Name]
[Company Name]
[Title]