

**Date:** [Insert Date]

**To:** [Recipient Name/Employer/Insurance Company]

**Address:** [Insert Address]

**Subject:** Notice of Temporary Disability Status and Rehabilitation Plan

Dear [Name of Contact Person or Department],

This letter is to formally notify you that [Patient Name] is currently under my medical care for a health condition that has resulted in a temporary disability. Based on my recent clinical evaluation, the patient is unable to perform their regular duties effective from [Start Date].

**Current Status:**

The patient is experiencing [Briefly state limitations, e.g., restricted mobility/cognitive fatigue], which prevents them from fulfilling the requirements of their role as [Job Title].

**Rehabilitation Plan:**

The patient has commenced a structured rehabilitation program which includes:

- [Specific Treatment 1, e.g., Physical Therapy sessions twice weekly]
- [Specific Treatment 2, e.g., Medication management and rest]
- [Specific Treatment 3, e.g., Gradual activity reintegration]

**Expected Duration:**

At this time, it is anticipated that the period of temporary disability will last until approximately [Estimated End Date]. A follow-up evaluation is scheduled for [Date] to reassess the patient's progress and ability to return to work, either with or without accommodations.

**Work Restrictions (if applicable):**

During this period, the patient is restricted from:

- [Restriction 1, e.g., Lifting more than 10 lbs]
- [Restriction 2, e.g., Prolonged standing or sitting]

Please contact my office at [Phone Number] if you require further medical documentation or clarification regarding this status.

Sincerely,

[Physician Signature]

**[Physician Name, Degree]**

[Medical Practice/Facility Name]

[License Number]