

Date: [Date]

To: [Claims Adjuster Name]
[Insurance Carrier Name]
[Address]
[City, State, Zip Code]

RE: Initial Disability Status Report

Employee Name: [Employee Full Name]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]
Employer: [Employer Name]

Dear [Claims Adjuster Name],

I am the treating physician for [Employee Name] regarding the work-related injury sustained on [Date of Injury]. This letter serves as the initial notification of the patient's disability status following our evaluation on [Date of Evaluation].

Diagnosis:

[List primary diagnosis/injuries]

Disability Status: (Check one)

- **Total Temporary Disability (TTD):** The patient is currently unable to perform any work duties. Estimated return to work date: [Date].
- **Partial Temporary Disability (Modified Duty):** The patient may return to work with the following restrictions:
 - Lifting/Carrying limit: [e.g., 10 lbs]
 - Standing/Walking limit: [e.g., 2 hours per day]
 - Other restrictions: [e.g., No overhead reaching, No repetitive typing]
- **Full Duty:** The patient may return to work with no restrictions.

Treatment Plan:

The current plan of care includes [e.g., physical therapy, specialist referral, medication, or surgery].

Follow-Up:

The patient is scheduled for a follow-up evaluation on [Date] to reassess their progress and disability status.

If you have any questions regarding this report, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Clinic/Medical Group Name]