Date: [Date]

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

Re: Workers' Compensation Status Letter

Claimant Name: [Patient Name]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]

To Whom It May Concern,

I am the treating physician for [Patient Name] regarding the work-related injury sustained on [Date of Injury].

Based on my most recent clinical evaluation on [Date of Evaluation], it is my medical opinion that the patient remains in **Temporary Total Disability (TTD)** status. Due to the nature of the injuries and the current physical limitations, the patient is unable to perform any type of gainful employment at this time, including sedentary or light-duty work.

Objective Findings and Clinical Justification:
[Briefly describe diagnosis or reasons for total restriction]

Current Treatment Plan:
[Briefly describe next steps, e.g., Physical Therapy, Surgery, Specialist Referral]

The patient is expected to remain in this status until their next follow-up evaluation scheduled for [Next Appointment Date], at which point their functional capacity will be reassessed.

If you have any questions regarding this status, please contact my office.

Sincerely,

[Physician Signature]
[Physician Name, Degree]
[Medical Facility Name]
[Phone Number]