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

[Date]

[Claims Examiner Name]
[Insurance Company Name]
[Address]
[City, State, Zip Code]

RE: Notice of Permanent Partial Disability (PPD) Status
Claimant Name: [Your Full Name]
Claim Number: [Your Claim Number]
Date of Injury: [Date of Incident]

Dear [Claims Examiner Name],

I am writing to formally address my workers' compensation claim status regarding Permanent Partial Disability (PPD). According to the medical evaluation performed by [Doctor's Name] on [Date], I have reached Maximum Medical Improvement (MMI).

The attached medical report indicates an impairment rating of [Percentage]% to the [Affected Body Part]. Based on this permanent functional limitation, I am requesting the commencement of PPD benefit payments as outlined by state regulations.

Please find the following documents enclosed for your review:

- Final Medical Evaluation/MMI Report
- Functional Capacity Evaluation (if applicable)
- Impairment Rating Documentation

Please confirm receipt of this letter and provide a written statement regarding the calculation and scheduling of my PPD award payments within [Number] days.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]