

[Date]

[Insurance Carrier Name]

[Claims Adjuster Name]

[Address]

[City, State, Zip Code]

RE: Workers' Compensation Return to Work Status

Employee Name: [Employee Full Name]

Claim Number: [Claim Number]

Date of Injury: [Date]

To Whom It May Concern,

This letter serves to formally notify you of the disability status and return-to-work eligibility for the above-named employee following their medical evaluation on [Date of Evaluation].

Based on the medical assessment by Dr. [Physician Name], the employee's status is as follows:

- **Full Duty:** The employee is cleared to return to their regular job duties without any restrictions effective [Date].
- **Modified Duty:** The employee may return to work with the following restrictions effective [Date] through [End Date/Next Evaluation]:
 - [List Restriction 1: e.g., No lifting over 10 lbs]
 - [List Restriction 2: e.g., No prolonged standing]
 - [List Restriction 3: e.g., Limited use of right arm]
- **Total Disability:** The employee remains temporarily totally disabled and is unable to return to work in any capacity at this time. The next re-evaluation is scheduled for [Date].

The employer [has / has not] confirmed that they can accommodate the modified duty restrictions listed above.

Please find the attached medical report and Work Status Note (Form [Number, if applicable]) for your records. If you have any questions regarding this update, please contact our office at [Phone Number].

Sincerely,

[Your Name/Signature]

[Title/Organization]

Attachment: Medical Progress Report / Work Status Form