Date: [Date]

RE: Workers' Compensation Disability Status Letter
Patient Name: [Patient First and Last Name]
Date of Birth: [DOB]
Date of Injury: [DOI]
Claim Number: [Claim #]

To Whom It May Concern,

I am the attending physician for [Patient Name] regarding the work-related injury sustained on [Date of Injury]. Based on my clinical evaluation and the patient's current physical condition, I am providing the following update on their disability status.

Diagnosis: [List Primary Diagnosis/Injuries]

Current Work Status (Check One):

- [ ] **Total Temporary Disability:** The patient is unable to perform any work at this time. Estimated return to work date: [Date].
- [ ] **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 is released to return to full work duties without restrictions effective [Date].

Treatment Plan:
The patient is currently undergoing [e.g., Physical Therapy, Medication Management, Specialist Referral]. The next follow-up appointment is scheduled for [Date]. At that time, their disability status will be re-evaluated.

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

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice Name]
[NPI Number]