

**Date:** [Insert Date]

**To:** [Claims Adjuster Name / Insurance Company]

**Address:** [Insert Address]

**Re:** Workers' Compensation Claim Status

**Patient Name:** [Insert Patient Name]

**Date of Birth:** [Insert DOB]

**Claim Number:** [Insert Claim Number]

**Date of Injury:** [Insert Date of Injury]

To Whom It May Concern,

This letter provides the current functional capacity and disability status for the above-referenced patient regarding the work-related injury sustained on [Date of Injury].

**I. Diagnosis:**

[Insert Diagnosis and ICD-10 Codes]

**II. Current Disability Status:**

Temporary Total Disability (Off work completely)

Temporary Partial Disability (May return to work with restrictions)

Permanent Partial Disability (Reached Maximum Medical Improvement)

**III. Functional Limitations / Work Restrictions:**

The patient is subject to the following restrictions effective [Start Date] through [End Date/Next Eval]:

- **Lifting/Carrying:** No more than [Number] lbs.
- **Pushing/Pulling:** No more than [Number] lbs. of force.
- **Postural:** No [Bending / Squatting / Climbing / Reaching above shoulder].
- **Mobility:** Limited [Walking / Standing] to [Number] hours per day.
- **Repetition:** No repetitive [Grasping / Typing / Fine Manipulation] with [Left/Right] hand.

**IV. Treatment Plan:**

The patient is currently undergoing [Physical Therapy / Medication Management / Specialist Referral]. The next evaluation is scheduled for [Date].

**V. Physician Statement:**

In my medical opinion, these restrictions are necessary to prevent further injury and facilitate recovery. Please contact my office if a modified-duty position is available that fits within these parameters.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Practice Name]

[Phone Number]