Date: [Date]

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

To Whom It May Concern,

This letter serves to provide a formal update on the disability status and continuing treatment plan for the above-named patient regarding the injury sustained on [Date of Injury].

Current Medical Status:
The patient remains under my clinical care. Following the most recent evaluation on [Date of Last Visit], the patient continues to experience [Brief description of symptoms/limitations].

Disability Status:
[Select one option below and delete the others]
- Total Temporary Disability: Patient is currently unable to perform any work duties.
- Partial Temporary Disability: Patient may return to work with the restrictions listed below.
- Permanent Disability: Patient has reached Maximum Medical Improvement (MMI).

Work Restrictions (if applicable):
[List specific restrictions, e.g., No lifting over 10 lbs, no prolonged standing, sedentary work only, etc.]

Continuing Treatment Plan:
The patient's ongoing recovery requires the following:
- [Frequency] Physical Therapy sessions.
- Follow-up evaluation in [Number] weeks.
- Continued use of [Medication/Braces/Equipment].

Projected Return to Full Duty:
[Estimated Date or "TBD based on recovery progress"]

If you require further clinical documentation or have questions regarding this status update, please contact my office.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical Facility Name]
[Phone Number]