[Date]

[Insurance Carrier Name]
[Claims Adjuster Name]
[Address]
[City, State, Zip Code]

RE: Workers' Compensation Disability Verification

Employee Name: [Employee Full Name]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]

To Whom It May Concern,

I am the treating physician for [Employee Name] regarding the work-related injury sustained on [Date of Injury]. This letter serves to verify the patient's current disability status and physical limitations.

Based on my most recent evaluation on [Date of Last Exam], I have determined the following status:

Work Status:
[ ] Total Temporary Disability (Unable to work in any capacity)
[ ] Partial Temporary Disability (Able to work with restrictions)
[ ] Released to Full Duty (No restrictions)

Effective Dates:
These restrictions are effective from [Start Date] through [Expected End Date/Follow-up Date].

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

The patient is currently following a treatment plan consisting of [briefly mention physical therapy, medication, or surgery]. I will re-evaluate the patient's condition on [Next Appointment Date] to determine if their disability status needs modification.

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

Sincerely,

[Physician Signature]
[Physician Printed Name]

[Medical Facility Name]
[License Number]