**STARTING, STOPPING, OR DENYING TIME LOSS**

Dear \_\_\_\_\_\_\_\_\_\_\_\_,

**Your benefits.**

Time-loss is <Drop down menu- **Starting\*, stopping, or denying TL**> effective (insert date).

Our goal is to help you heal and return to work. Please give me a call me at the number below to talk about how I may assist.

We are <drop down- Stop or Denying> payment of your time loss compensation because:

*{insert drop down}*

* *You have returned to work.*
* *Your doctor has released you to return to work.*
* *You have been determined to be able to work based on transferable skills.*

<Free Text Box>

\*If starting time-loss, a copy of this letter to the worker must be submitted to the department.

If you have questions, please contact me at the phone number listed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Adjudicator Date Phone