Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

	5. Doctor's Name and Degree	(for transmission purposes only)	Date Being Sent
1. Injured Employee's Name	6. Clinic/Facility Name	9. Employer's Name	
2. Date of Injury / 3. Social Security Number (last 4) XXX-XX-	7. Clinic/Facility/Doctor Phone & Fax	10. Employer's Fax # or Email Address (if known)	
4. Employee's Description of Injury/Accident	8. Clinic/Facility/Doctor Address (street address)	11. Insurance Carrier	
	City State Zip	12. Carrier's Fax # or Email Address (if known)	

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8		Other
Standing	☐☐☐☐☐	
Sitting	☐☐☐☐☐	
Kneeling/Squatting	☐☐☐☐☐	
Bending/Stooping	☐☐☐☐☐	
Pushing/Pulling	☐☐☐☐☐	
Twisting	☐☐☐☐☐	
Other:	☐☐☐☐☐	

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand/Wrist
☐ Right Hand/Wrist
☐ Left Arm
☐ Right Arm
☐ Neck
☐ Left Leg
☐ Right Leg
☐ Back
☐ Left Foot/Ankle
☐ Right Foot/Ankle

Other:

16. OTHER RESTRICTIONS (if any):

17. MOTION RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8		Other
Walking	☐☐☐☐☐	
Climbing stairs/ladders	☐☐☐☐☐	
Grasping/Squeezing	☐☐☐☐☐	
Wrist flexion/extension	☐☐☐☐☐	
Reaching	☐☐☐☐☐	
Overhead Reaching	☐☐☐☐☐	
Keyboarding	☐☐☐☐☐	

Other:

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day

☐ May not perform any lifting/carrying

Other:

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: _____
☐ Sit/Stretch breaks of _____ per _____
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / _____ hours/day work:
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep _____ ☐ elevated ☐ clean & dry
☐ No skin contact with: _____
☐ Dressing changes necessary at work
☐ No running

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at _____ : _____ am/pm
☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm
☐ Physical medicine _____ X per week for _____ weeks starting on _____ (date) at _____ : _____ am/pm
☐ Special studies (list): _____ on _____ (date) at _____ : _____ am/pm
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
Discharge Time			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor

Frequently Asked Questions
Work Status Report (DWC Form-073)

Under what circumstances am I required to file the DWC Form-073?
Filing requirements for DWC Form-073 vary depending on the type of doctor filing the Work Status Report. The specific requirements are shown in the chart below.

Type of Doctor	When to File DWC Form-073	Where to File	Delivery Method	Deadline
Treating Doctor or Referral Doctor	• after the initial examination of the injured employee, regardless of the employee's work status • when there is a change in the injured employee's work status • when there is a substantial change in the injured employee's activity restrictions • on a schedule requested by the insurance carrier as long as it is based on the injured employee's scheduled appointments with the doctor (not to exceed one report every two weeks)	• injured employee	hand deliver	at the time of the examination
		• insurance carrier	fax or e-mail	within 2 working days of the examination
		• employer	fax or e-mail unless recipient has not provided these numbers; then by personal delivery or mail	
	• after receiving a set of functional job descriptions, from the employer or insurance carrier listing modified duty positions, including the physical and time requirements of the positions, that the employer has available for the injured employee to work • after receiving a DWC Form-073 from a RME Doctor that indicates the injured employee is able to return to work with or without restrictions	• injured employee	hand deliver unless no appointment is scheduled before deadline; then fax or e-mail unless recipient has not provided these numbers; then by mail	within 7 days of receiving job description or RME opinion
		• insurance carrier • employer	fax or e-mail	
Designated Doctor	• after examination of an injured employee to address any question relating to return to work **NOTE:** The Designated Doctor must file a narrative report along with the DWC Form-073.	• injured employee • injured employee's representative (if any)	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means	within 7 working days of the examination
		• insurance carrier • treating doctor	fax or e-mail	
		• TDI-DWC	fax to 512-490-1047	
RME Doctor selected by insurance carrier	• after examination of an injured employee (subsequent to a Designated Doctor's examination), if the RME doctor determines that the injured employee can return to work immediately with or without restrictions	• injured employee • injured employee's representative (if any)	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means	within 7 days of the examination
		• insurance carrier • treating doctor	fax or e-mail	
RME Doctor selected by DWC	Not applicable. TDI-DWC's medical examinations are ordered in accordance with §408.0041, Texas Labor Code, and applicable Division of Workers' Compensation rules.			

Where can I find more information about the DWC Form-073?
For complete requirements regarding the filing of this report, see 28 TAC §§126.6, 127.10, and 129.5. These rules are available on the TDI website at www.tdi.state.tx.us/wc/rules/index.html. If you have additional questions, call *Comp Connection for Health Care Providers* at 1-800-372-7713 (804-4000 in the Austin area) and select option 3.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).