

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.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. La Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 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	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

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)

<p>14. POSTURE RESTRICTIONS (if any):</p> <p>Max Hours per day: 0 2 4 6 8 Other _____</p> <p>Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p>17. MOTION RESTRICTIONS (if any):</p> <p>Max Hours per day: 0 2 4 6 8 Other _____</p> <p>Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Grasping/Squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Overhead Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p>19. MISC. RESTRICTIONS (if any):</p> <p><input type="checkbox"/> Max hours per day of work: _____</p> <p><input type="checkbox"/> Sit/Stretch breaks of _____ per _____</p> <p><input type="checkbox"/> Must wear splint/cast at work</p> <p><input type="checkbox"/> Must use crutches at all times</p> <p><input type="checkbox"/> No driving/operating heavy equipment</p> <p><input type="checkbox"/> Can only drive automatic transmission</p> <p><input type="checkbox"/> No work / <input type="checkbox"/> _____ hours/day work: <input type="checkbox"/> in extreme hot/cold environments <input type="checkbox"/> at heights or on scaffolding</p> <p><input type="checkbox"/> Must keep _____: <input type="checkbox"/> Elevated <input type="checkbox"/> Clean & Dry</p> <p><input type="checkbox"/> No skin contact with: _____</p> <p><input type="checkbox"/> Dressing changes necessary at work</p> <p><input type="checkbox"/> No Running</p>
<p>15. RESTRICTIONS SPECIFIC TO (if applicable):</p> <p><input type="checkbox"/> L Hand/Wrist <input type="checkbox"/> R Hand/Wrist</p> <p><input type="checkbox"/> L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> L Leg <input type="checkbox"/> R Leg <input type="checkbox"/> Back</p> <p><input type="checkbox"/> L Foot/Ankle <input type="checkbox"/> R Foot/Ankle</p> <p><input type="checkbox"/> Other: _____</p>	<p>18. LIFT/CARRY RESTRICTIONS (if any):</p> <p><input type="checkbox"/> May not lift/carry objects more than ____ lbs. for more than ____ hours per day</p> <p><input type="checkbox"/> May not perform any lifting/carrying</p> <p><input type="checkbox"/> Other: _____</p>	<p>20. MEDICATION RESTRICTIONS (if any):</p> <p><input type="checkbox"/> Must take prescription medication(s)</p> <p><input type="checkbox"/> Advised to take over-the-counter meds</p> <p><input type="checkbox"/> Medication may make drowsy (possible Safety/driving issues)</p>
<p>16. OTHER RESTRICTIONS (if any):</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>* 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.</p>		

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

<p>21. Work Injury Diagnosis Information:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>22. Expected Follow-up Services Include:</p> <p><input type="checkbox"/> Evaluation by the treating doctor on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> Referral to/Consult with _____ on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> Physical medicine __ X per week for __ weeks starting on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> Special studies (list): _____ on _____ (date) at ____ : ____ am/pm</p> <p><input type="checkbox"/> None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.</p>		
<p>Date / Time of Visit</p> <p>Discharge Time</p>	<p>EMPLOYEE'S SIGNATURE</p> <p>DOCTOR'S SIGNATURE</p>	<p>Visit Type:</p> <p><input type="checkbox"/> Initial</p> <p><input type="checkbox"/> Follow-up</p>	<p>Role of Doctor:</p> <p><input type="checkbox"/> Designated doctor <input type="checkbox"/> Treating doctor</p> <p><input type="checkbox"/> Carrier-selected RME <input type="checkbox"/> Referral doctor</p> <p><input type="checkbox"/> DWC-selected RME <input type="checkbox"/> Consulting doctor</p> <p><input type="checkbox"/> Other doctor</p>



**DWC FORM - 73
WORK STATUS REPORT INSTRUCTIONS**

PART I: GENERAL INFORMATION - Contains space to record general information about the employee and the doctor/clinic. This section includes space to record a high-level generic description of the injury or condition (e.g. broken right arm, strained left knee, etc) and how it occurred. Also contains space to record the name and facsimile number or email address of the insurance carrier (carrier) and the employer, as well as the date of transmission. This space is intended to eliminate the need for a separate facsimile cover page. **Because this information is intended primarily for transmission purposes, the report may be provided to the injured employee (employee) at the time of the examination, even if the information required in this section is not yet available.**

PART II: WORK STATUS INFORMATION - The doctor is required to indicate the employee's current work status. There are three choices: able to work without restrictions; able to work with restrictions; and prevented from returning to work.

If the doctor believes that the employee can only work with restrictions or is prevented from returning to work, the doctor is **required** to provide an estimated date of expiration for the restrictions. These estimates are required to enhance claims management and to provide the employer with information that can be used to plan work coverage and plan for the employee's return to work (whether with or without restrictions). **An estimated expiration is speculative in nature. The further the date is projected, the less accurate it may be. Estimations are not binding and may be changed as needed based upon the condition and progress of the employee by filing a subsequent Work Status Report. Doctors need to provide reasonable estimates based upon the nature of the employee's injury.**

In addition, a doctor who believes that an employee is prevented from returning to work is required to provide a specific explanation of how the condition prevents the employee from returning to work. One of the goals of the Texas Workers' Compensation Act is to ensure a speedy return to employment which is safe, meaningful, and commensurate with the abilities of the employee. **It is the responsibility of the doctor treating or examining an injured employee to identify what the employee may be able to safely perform. It is not the doctor's responsibility to ensure that the employer has a modified duty position that meets those restrictions - that is the employer's responsibility if the employer chooses to try to accommodate the restrictions.**

PART III: ACTIVITY RESTRICTIONS - If the doctor indicates that the employee is able to work with restrictions, the doctor is to indicate those restrictions in this section. **The doctor is only supposed to indicate what restrictions are in place because of the workers' compensation injury.** Any restrictions that may have existed due to other conditions are assumed to remain and should not be duplicated here. The doctor should go over the restrictions with the employee at the time the report is provided.

The section was designed to include check boxes for common restrictions that may apply to the employee. If a box is not checked, it is assumed that there is no restriction on that activity. Also, if no specific body part is indicated in box #15, then it should be understood that the restrictions are whole body restrictions.

PART IV: DIAGNOSIS/FOLLOW-UP INFORMATION - Provides general diagnosis information and provides upcoming appointment information (if known at time of filing report) so that the carrier can better manage the claim and the employer can be aware of time where the employee might not be available for work. In addition, providing this information may reduce calls from carriers and employers seeking the information. **However, doctors need ensure that the diagnosis information provided to the employer is at a general level and does not violate any confidentiality laws relating to the employee's privacy rights.**

The Work Status Report is primarily designed to be filed by the treating or referral doctor. However, other doctors can and will occasionally need to file this report. The following describes the various roles that doctors can play within the system:

Treating: Doctor chosen by and primarily responsible for employee's injury-related health care.	Referral: Doctor who was selected by the treating doctor to treat one or more aspects of the employee's medical condition.
Consulting: Doctor who was selected by the treating doctor to provide an opinion on the employee's medical condition.	Carrier-selected RME: Doctor selected by the insurance carrier.
Designated: Doctor selected by the Division to evaluate whether the employee's medical condition has improved sufficiently to allow a return to work (only for Supplemental Income Benefits claims).	DWC-selected RME: Doctor selected by DWC.
	Other: Doctor who fits none of the other descriptions.

Basic Instructions - Provide to injured employee at time of examination and fax or electronically transmit to: insurance carrier and employer by the end of the second working day following the date of the examination. Report must be filed after initial visit, when there is a change in work status or a substantial change in activity restrictions, and on the schedule requested by or through the carrier (not to exceed one report every two weeks). Also file within 7 days of receiving functional job descriptions from the employer or a Work Status Report from a Required Medical Examination doctor that indicates that the employee is able to return to work with or without restrictions.

Rules 126.6, 129.5, and 130.110 lay out the complete requirements for filing this report (in addition, Rule 129.6 provides information on how the report might be used). The complete text to these rules is available on the Division's web site at www.tdi.state.tx.us.

