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 (DWC) and may be entitled to certain medical and income benefits. For further information call DWC at 800-252-7031

Empleado - Es requerido que usted reporte su lesión a su empleador dentro de 30 días si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte del Departamento de Seguros de Texas, División de Compensación para Trabajadores (DWC), y es posible que tenga derecho a recibir ciertos beneficios médicos y de ingresos. Para obtener más información llame a DWC al 800-252-7031.

DWC073

Texas Workers' Compensation Work Status Report

I. GENERAL INFORMATION

Date Sent (for transmission purposes only)**:**

1. Injured Employee's Name	**5a. Doctor's/Delegating Doctor's Name and Degree**	**5b. PA / APRN Name** (if completing form)
2. Date of Injury / **3. Social Security Number** (last four) XXX-XX-	**6. Facility Name**	**9. Employer's Name**
4. Employee's Description of Injury/Accident	**7. Facility/Doctor Phone and Fax Numbers**	**10. Employer's Fax Number or Email Address** (if known)
	8. Facility/Doctor Address (Street, City, State, ZIP Code)	**11. Insurance Carrier**
		12. Carrier's Fax Number or Email Address (if known)

II. WORK STATUS INFORMATION (Fully complete one box including estimated dates, and a description in 13c, if 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 _____/ _____ / _____ **without restrictions**; **OR**

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

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

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

III. ACTIVITY RESTRICTIONS (Only complete if box 13b 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 ☐ Left leg
☐ Right hand/wrist ☐ Right leg
☐ Left arm ☐ Back
☐ Right arm ☐ Left foot/ankle
☐ Neck ☐ Right foot/ankle
Other:

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 skin contact with:
☐ No running
☐ Dressing changes necessary at work

☐ No work /_____ hours/day work:
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep_____
☐ elevated ☐ clean & dry

16. Other Restrictions (if any)

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)

IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____/ _____/ _____ at _____:_____ a.m./p.m.
☐ Referral to/consult with _____ on _____/ _____/ _____ at _____:_____ a.m./p.m.
☐ Physical medicine _____ X per week for _____ weeks starting on _____/ _____/ _____ at _____:_____ a.m./p.m.
☐ Special studies (list): _____ on _____/ _____/ _____ at _____:_____ a.m./p.m.
☐ 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	Visit Type:	Role of Health Care Practitioner:
Discharge Time:	Health Care Practitioner's Signature / License #	☐ Initial ☐ Follow-up	☐ Treating doctor ☐ Consulting doctor ☐ Designated doctor ☐ Referral doctor ☐ PA ☐ Other doctor ☐ RME doctor ☐ APRN

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

Under what circumstances am I required to file 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 ***Referral Doctor*** ***Delegated Physician Assistant (PA)*** ***or*** ***Delegated Advanced Practice Registered Nurse (APRN)***	• 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; electronic transmission, with agreement (fax, email, or similar method)	at the time of the examination
		• insurance carrier	electronic transmission	within 2 working days of the examination
		• employer	electronic transmission unless recipient has not provided a fax number or email address; 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 required medical exam (RME) doctor that indicates the injured employee can return to work with or without restrictions	• injured employee	hand deliver unless no appointment is scheduled before deadline; then electronic transmission unless recipient has not provided a fax number or email address; then by mail	within 7 days of receiving job description or RME opinion
		• insurance carrier • employer	electronic transmission	
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 DWC Form-073.	• injured employee • injured employee's representative (if any)	electronic transmission unless recipient has not provided a fax number or email address; then by other verifiable means	within 7 working days of the examination
		• insurance carrier • treating doctor	electronic transmission	
		• division	fax to 512-490-1047	
RME Doctor	• 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)	electronic transmission unless recipient has not provided a fax number or email address; then by other verifiable means	within 7 days of the examination
		• insurance carrier • treating doctor	electronic transmission	

Where can I find more information about DWC Form-073?
For complete requirements regarding the filing of this report, see 28 Texas Administrative Code §§126.6, 127.10, and 129.5. These rules are available on the TDI website at http://www.tdi.texas.gov/wc/rules/index.html. If you have additional questions, call *Comp Connection for Health Care Providers* at 1-800-372-7713 (512-804-4000 in the Austin area) and select option 3.

NOTE: With few exceptions, upon your request, you are entitled to be informed about the information DWC collects about you; to get and review the information (Government Code §§552.021 and 552.023); and to have DWC correct information that is incorrect (Government Code, §559.004). For more information, contact agencycounsel@tdi.texas.gov or you may refer to the Corrections Procedure section at www.tdi.texas.gov.