



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:	
<input type="checkbox"/> a) will allow the employee to return to work as of ____/____/____ without <u>restrictions</u> ; OR	
<input type="checkbox"/> b) will allow the employee to return to work as of ____/____/____ with <u>the restrictions</u> identified in PART III, which are expected to last through ____/____/____; OR	
<input type="checkbox"/> 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):		17. Motion Restrictions (if any):	19. Misc. Restrictions (if any):
Max hours per day 0 2 4 6 8 Other:		Max hours per day 0 2 4 6 8 Other:	<input type="checkbox"/> Max hours per day of work: _____
Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Sit/stretch breaks of _____ per _____
Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Must wear splint/cast at work
Kneeling/squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Grasping/squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Must use crutches at all times
Bending/stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No driving/operating heavy equipment
Pushing/pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Can only drive automatic transmission
Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Overhead reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No skin contact with:
Other:		Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> No running
15. Restrictions Specific To (if applicable):		Other:	<input type="checkbox"/> Dressing changes necessary at work
<input type="checkbox"/> Left hand/wrist <input type="checkbox"/> Left leg		18. Lift/Carry Restrictions (if any):	<input type="checkbox"/> No work / _____ hours/day work: <input type="checkbox"/> in extreme hot/cold environments <input type="checkbox"/> at heights or on scaffolding
<input type="checkbox"/> Right hand/wrist <input type="checkbox"/> Right leg			
<input type="checkbox"/> Left arm <input type="checkbox"/> Back			
<input type="checkbox"/> Right arm <input type="checkbox"/> Left foot/ankle		<input type="checkbox"/> May not lift/carry objects more than _____ lbs. for more than _____ hours per day.	<input type="checkbox"/> Must keep _____ <input type="checkbox"/> elevated <input type="checkbox"/> clean & dry
<input type="checkbox"/> Neck <input type="checkbox"/> Right foot/ankle			
Other:		Other:	
16. Other Restrictions (if any)		20. Medication Restrictions (if any):	
		<input type="checkbox"/> Must take prescription medication(s)	
		<input type="checkbox"/> Advised to take over-the-counter meds	
		<input type="checkbox"/> 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:	
		<input type="checkbox"/> Evaluation by the treating doctor on ____/____/____ at ____:____ a.m./p.m.	
		<input type="checkbox"/> Referral to/consult with _____ on ____/____/____ at ____:____ a.m./p.m.	
		<input type="checkbox"/> Physical medicine _____ X per week for _____ weeks starting on ____/____/____ at ____:____ a.m./p.m.	
		<input type="checkbox"/> Special studies (list): _____ on ____/____/____ at ____:____ a.m./p.m.	
		<input type="checkbox"/> 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:
		<input type="checkbox"/> Initial	<input type="checkbox"/> Treating doctor <input type="checkbox"/> Consulting doctor <input type="checkbox"/> Designated doctor
Discharge Time:	Health Care Practitioner's Signature / License #	<input type="checkbox"/> Follow-up	<input type="checkbox"/> Referral doctor <input type="checkbox"/> PA <input type="checkbox"/> Other doctor
			<input type="checkbox"/> RME doctor <input type="checkbox"/> 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)	<ul style="list-style-type: none"> 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	
	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.