WORKERS' COMP

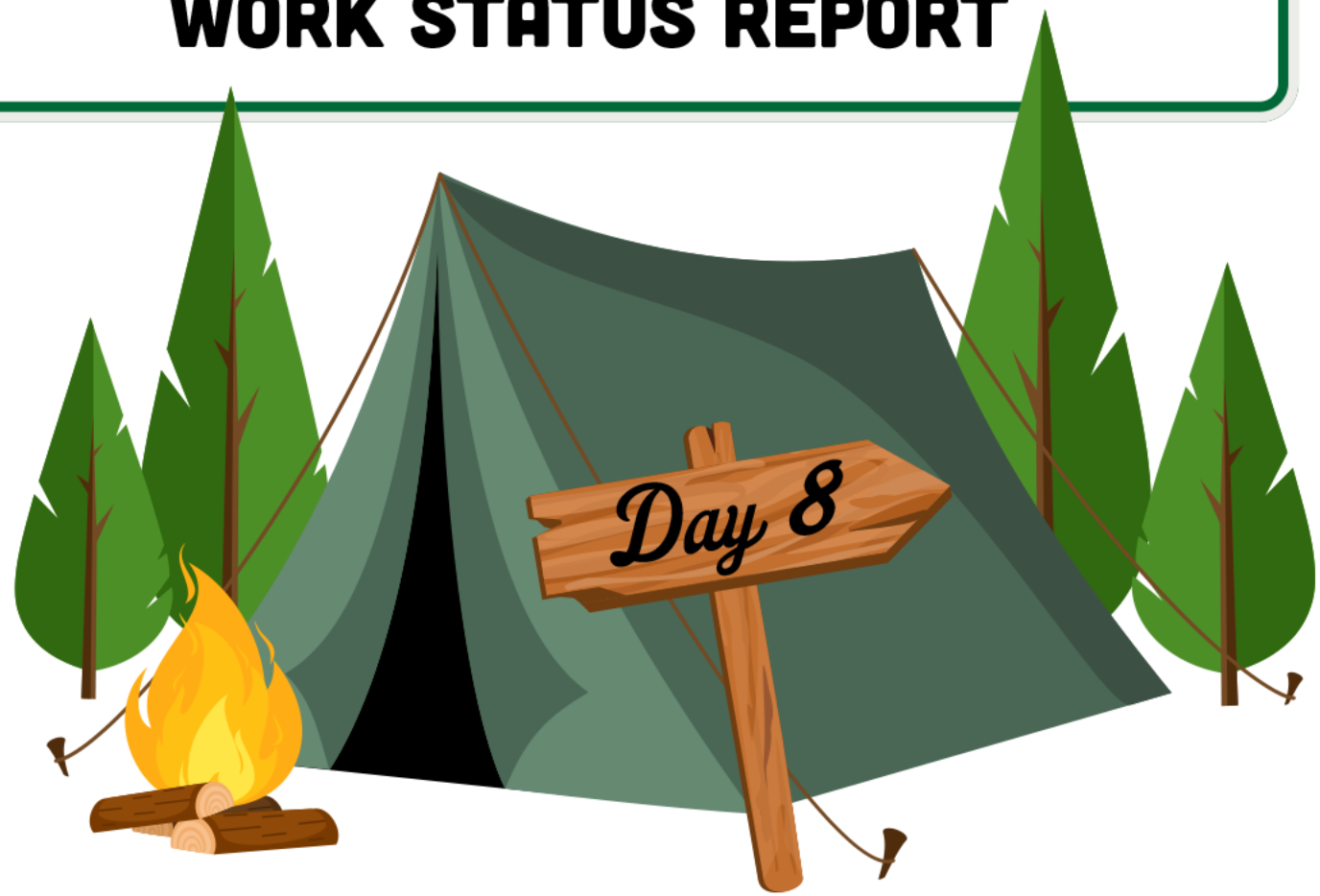
BOOT CAMP

Training

PART 2

2026

RETURN TO WORK FOR HEALTH CARE PROVIDERS >>> *and the* <<< WORK STATUS REPORT

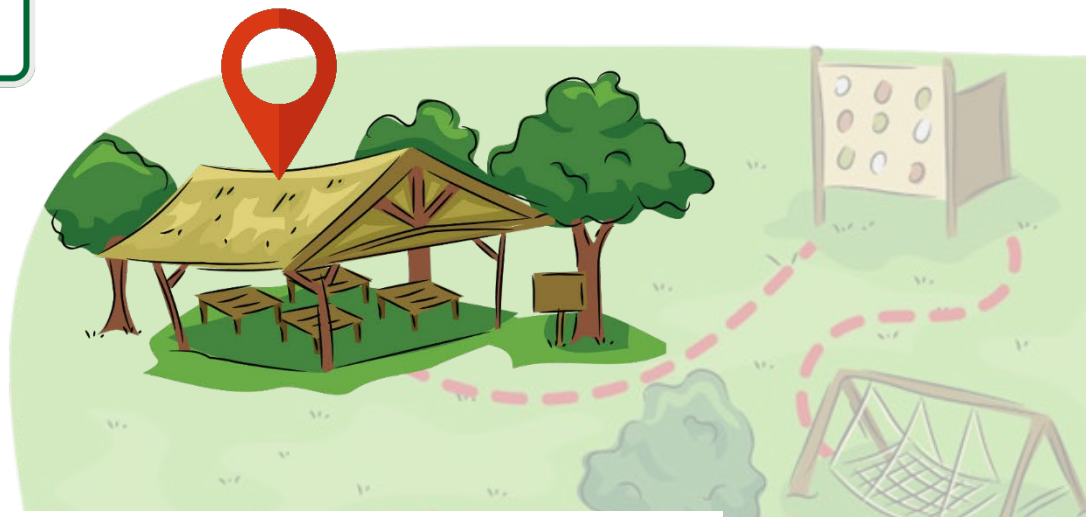


TDI Division of Workers' Compensation

Day 8

WORKERS' COMP BOOT CAMP Training PART 2 2026

RETURN TO WORK FOR HEALTH CARE PROVIDERS >>> and the <<< WORK STATUS REPORT



Learning Objectives

- Know the benefits of recovering while on the job and reducing medically unnecessary time away from the job.
- Know how to complete and understand the Work Status Report.
- Know the rule that addresses return to work and the form.

Disclaimer

This presentation is updated as of **July, 6 2026,** and is for educational purposes only and provides general information. It is not a substitute for a full review of statutes and rules.

System participants are responsible for knowing and complying with the applicable sections of the Texas Insurance Code (Insurance Code), Texas Labor Code (Labor Code), and Texas Administrative Code (TAC).

Any opinions expressed by the speakers are personal and do not constitute or reflect any statement of policy by the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Goals and Legislative Intent

Goals; Legislative Intent; General Workers' Compensation Mission of Department

A basic goal of the Texas workers' compensation system is to facilitate the injured employee's return to employment as soon as it is considered safe and appropriate by the employee's health care provider.

Intent of the Legislature Implementing this Goal

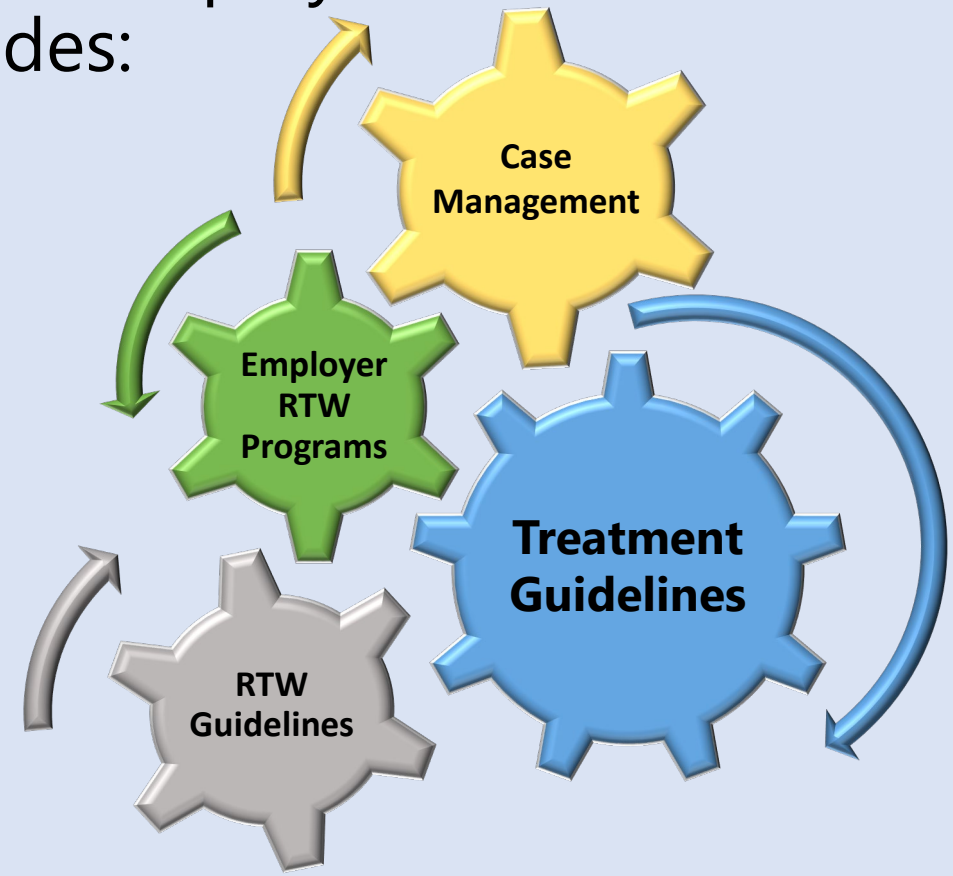
The workers' compensation system must:

- Encourage the safe and timely return of injured employees to productive roles in the workplace.
- Provide timely, appropriate, and high-quality medical care supporting restoration of the injured employee's physical condition and earning capacity.

Structure for RTW

Promoting safe and timely return of injured employees to productive roles in the workforce includes:

- Treatment guidelines.
- RTW guidelines.
- Employer RTW programs.
- Case management.



Support for RTW

Medical Associations Advocate Working Through Recovery

- American College of Occupational and Environmental Medicine (ACOEM).
- International Association of Industrial Accident Boards and Commissions (IAIABC).
- American Medical Association (AMA).
- American Academy of Orthopedic Surgeons (AAOS).
- And many more.

Consequences of Medically Unnecessary Lost Time

- Poor mental and physical health.
- Financial hardship.
- Family issues.
- Social isolation.
- Lose connection to employer.
- Lose job related benefits.
- Could lose job.

Benefits of Working

- Recover faster.
- Prevent de-conditioning.
- Minimize social and psychological dysfunction.
- Retain job skills.
- Retain employment.

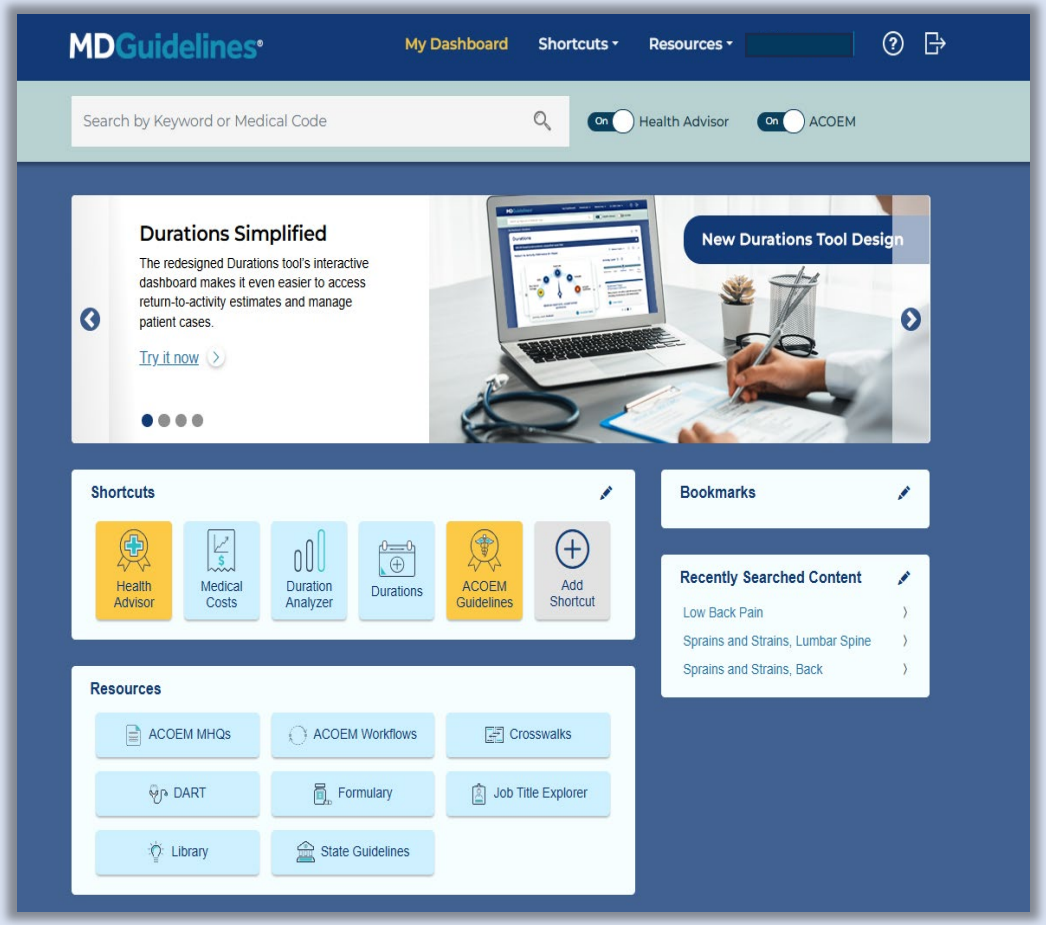
Treating Doctor and other Health Care Practitioner's Role in RTW

Treating Doctor's Role

- Establish RTW or stay at work (SAW) expectations with the injured employee, beginning with the first visit, and discuss often.
- Communicate regularly with referral and ancillary health care providers about the injured employee's care and RTW expectations.
- Incorporate working into your treatment plan.
- Use DWC's adopted RTW guideline (MDGuidelines) for disability durations.*

*Networks use their own RTW guidelines.

Treating Doctor's Role



Insurance carriers, health care practitioners, and employers must use DWC's adopted non-network RTW guidelines for the evaluation of expected or average RTW time frames.

MDGuidelines

www.mdguidelines.com

Phone: 800-442-4519

Treating Doctor's Role

- Be aware of non-medical factors that may interfere with successful treatment and RTW.
- Encourage the injured employee to take an active role in their recovery.
- Explain that pain doesn't mean they cannot be active or working.

Treating Doctor's Role

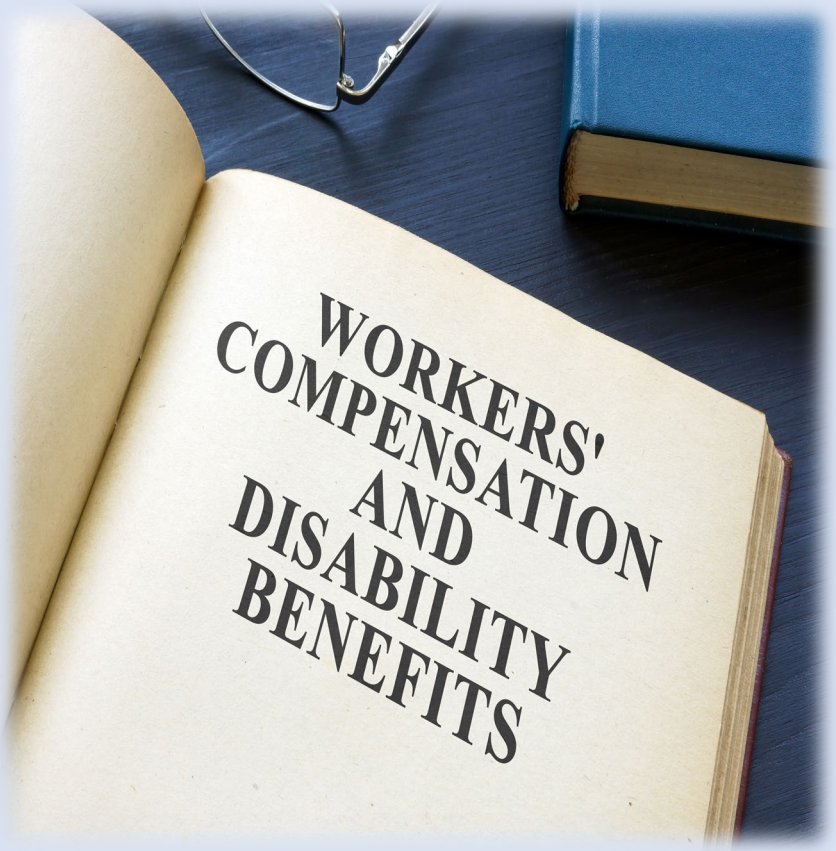
- Assess the injured employee's abilities in relation to functions or duties not **"jobs."**
- Identify and focus on what the injured employee can do.
- Talk to the employer about options for restricted and modified assignments.
- Do not take an injured employee off work just because they can not perform their exact job, or that the employer does not offer restricted or modified assignments.

Treating Doctor's Role

- Specify the injured employee's abilities on the DWC Form-073.
- Do not wait until the injured employee is at maximum medical improvement (MMI) before releasing the injured employee to work.
- Release the injured employee to work as soon as it is medically appropriate, it is the employer's responsibility to make employment decisions.

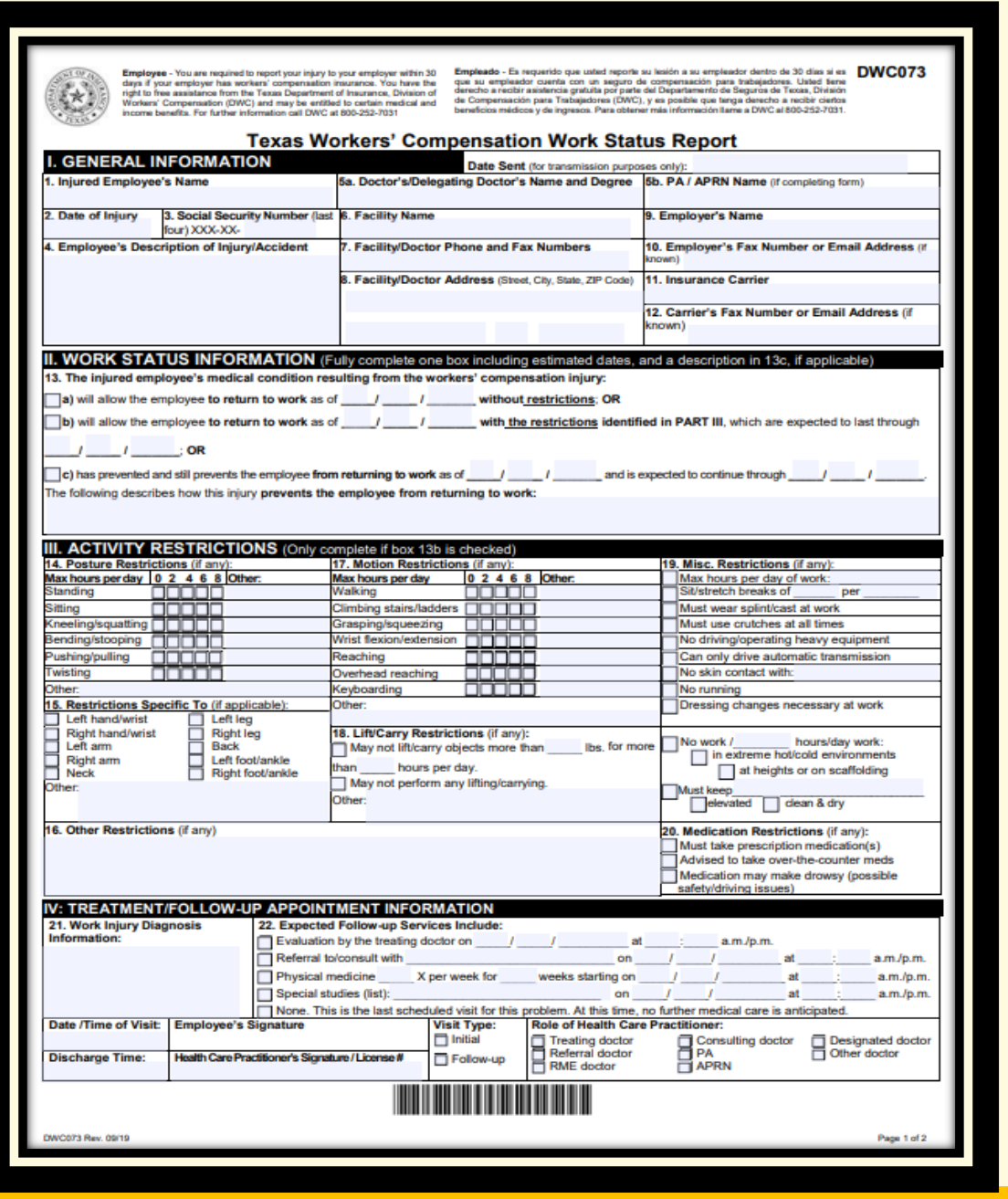
What if the employer does not have a job for the injured employee?

- Does not impact eligibility for income benefits.
- Entitled to temporary income benefits (TIBs) to compensate for lost wages until reaching MMI.
- TIBs are adjusted to match fluctuations in employee's earnings.



Referral Doctor and Ancillary Health Care Practitioners

- Collaborate with the treating doctor and injured employee on establishing RTW goals.
- Coordinate the injured employee's health care and work status with the treating doctor.
- Referral doctor should submit the DWC Form-073, when required.



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:

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 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

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

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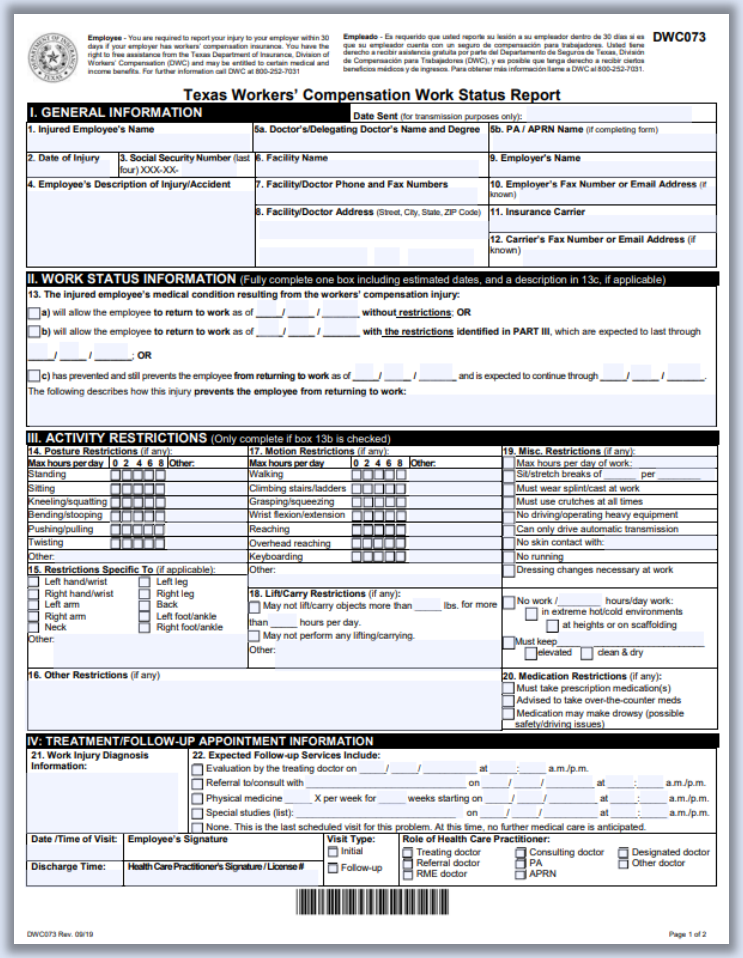
Completing and Billing for the DWC Form-073

What is the DWC Form-073?

A communication tool used to inform the insurance carrier, employer, and injured employee of the injured employee's functional abilities and whether the injured employee can work, with or without restrictions, or is unable to work.



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

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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
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☐ Right arm ☐ Left foot/ankle
☐ Neck ☐ 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 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

20. Medication Restrictions (if any):

☐ Must take prescription medication(s)
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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

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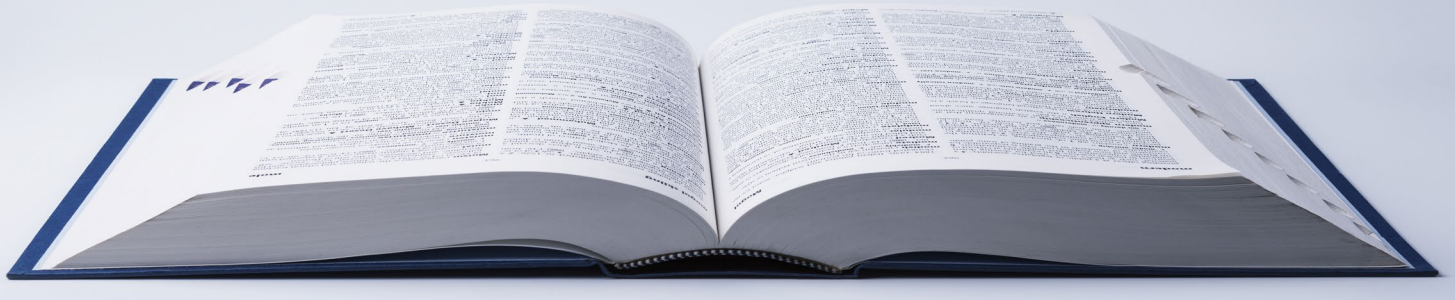
When is a DWC Form-073 submitted?

- On the initial visit with the treating doctor and referral doctor; or delegated physician assistant (PA), or delegated advanced practice registered nurse (APRN), regardless of work status.
- When activity restrictions substantially change or work status changes.
- At the request of the insurance carrier:
  - Must be based on scheduled appointments with the injured employee and not more than once every two weeks.

Definitions

Work status – refers to whether the injured employee's medical condition:

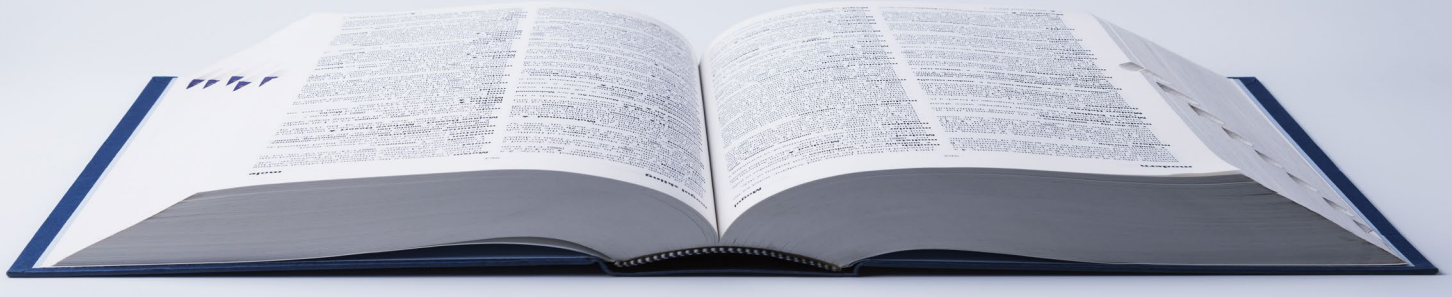
- Allows the injured employee to RTW without restrictions (which is not equivalent to MMI);
- Allows the injured employee to RTW with restrictions; or
- Prevents the injured employee from RTW.



Definitions

Substantial change in activity restrictions – means a change in activity restrictions caused by a change in the injured employee's medical condition, which either:

- Prevents the injured employee from working under the previous restrictions.
- Allows the injured employee to work in an expanded and more strenuous capacity than the prior restrictions permitted (approaching the injured employee's normal job).



Who gets the DWC Form-073?

The injured employee

- At the time of the examination.
- By hand delivery or electronic transmission if the injured employee agrees to receive the report by electronic transmission.

Who gets the DWC Form-073?

The employer

- Not later than the end of the second working day after the date of examination.
- By electronic transmission if the employer's facsimile number or email address has been provided; otherwise, the report shall be filed by personal delivery or mail.

Who gets the DWC Form-073?

The insurance carrier

- Sent to insurance carrier not later than the end of the **second working day** after the date of examination.
- By electronic transmission.

Part II: Work Status Information

Employee can work *without* restrictions

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): 09-01-2024

1. Injured Employee's Name: Augusta Wind	5a. Doctor's/Delegating Doctor's Name and Degree: Wiley Waites MD	5b. PA / APRN Name (if completing form): Theo Suess, APRN
2. Date of Injury: 09-01-2024 / 3. Social Security Number (last four) XXX-XX-: 0123	6. Facility Name: Any Medical Clinic	9. Employer's Name: Yard of the Month Company
4. Employee's Description of Injury/Accident: Fell into a truck at worksite with cut to right lower leg.	7. Facility/Doctor Phone and Fax Numbers: 316-262-1492 / 316-262-1493	10. Employer's Fax Number or Email Address (if known): 555-444-3210
	8. Facility/Doctor Address (Street, City, State, ZIP Code): 900 E. Mulberry Street, Whoville TX 99999	11. Insurance Carrier: Wonka Insurance Company
		12. Carrier's Fax Number or Email Address (if known): 444-555-6789

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:

[X] **a)** will allow the employee **to return to work** as of 09 / 01 / 2024 **without restrictions**; **OR**

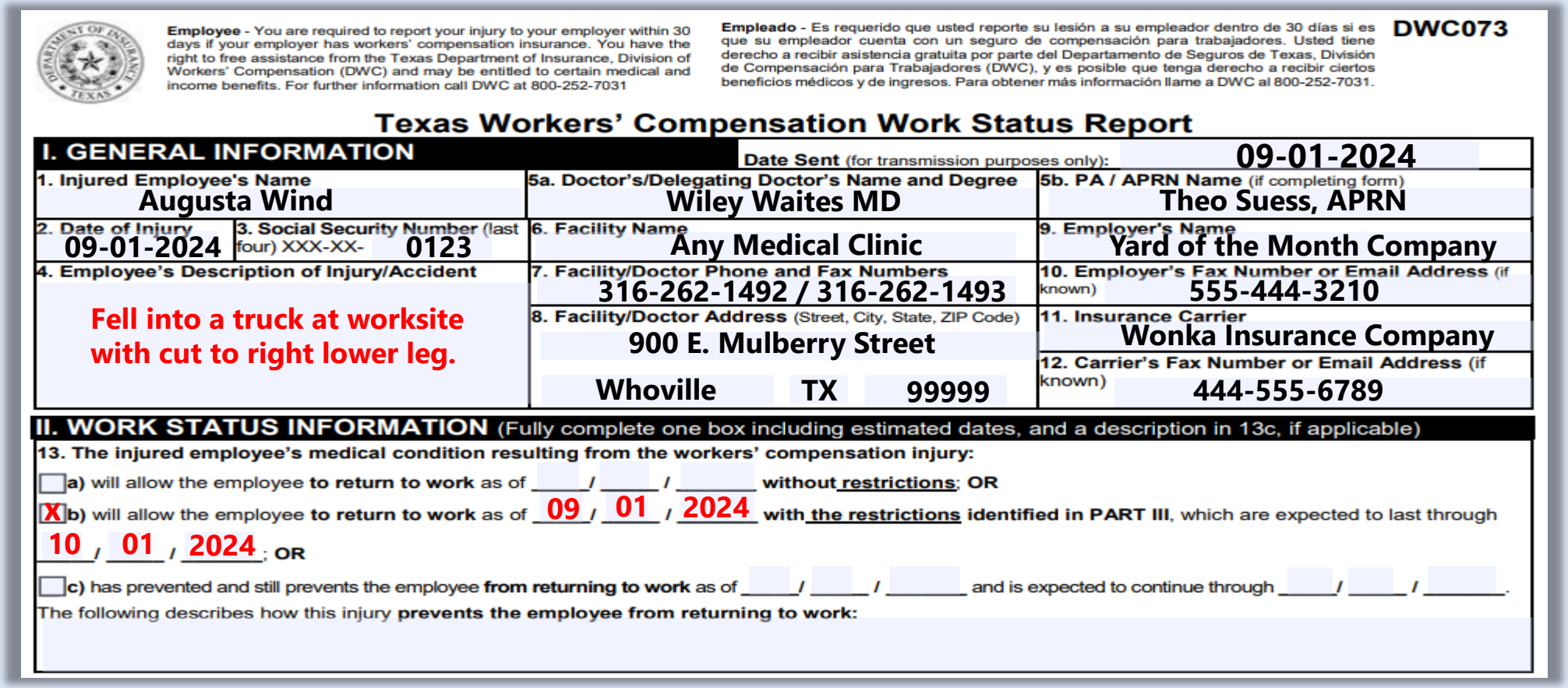
[ ] **b)** will allow the employee **to return to work** as of ____/____/____ **with the restrictions identified in PART III**, which are expected to last through ____/____/____; **OR**

[ ] **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:**

Part II: Work Status Information

Employee can work *with* restrictions



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2. Date of Injury: 09-01-2024 / 3. Social Security Number (last four) XXX-XX-: 0123	6. Facility Name: Any Medical Clinic	9. Employer's Name: Yard of the Month Company
4. Employee's Description of Injury/Accident: Fell into a truck at worksite with cut to right lower leg.	7. Facility/Doctor Phone and Fax Numbers: 316-262-1492 / 316-262-1493	10. Employer's Fax Number or Email Address (if known): 555-444-3210
	8. Facility/Doctor Address (Street, City, State, ZIP Code): 900 E. Mulberry Street, Whoville TX 99999	11. Insurance Carrier: Wonka Insurance Company
		12. Carrier's Fax Number or Email Address (if known): 444-555-6789

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 09 / 01 / 2024 **with the restrictions identified in PART III**, which are expected to last through 10 / 01 / 2024; **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:**

Part III: Activity Restrictions

Specific activity restrictions

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	X	☐	☐	☐	☐	
Bending/stooping	☐	☐	☐	☐	☐	
Pushing/pulling	X	☐	☐	☐	☐	
Twisting	X	☐	☐	☐	☐	
Other:						

15. Restrictions Specific To (if applicable):

- ☐ Left hand/wrist
- ☐ Right hand/wrist
- ☐ Left arm
- ☐ Right arm
- ☐ Neck
- ☐ Left leg
- X Right leg
- ☐ Back
- ☐ Left foot/ankle
- ☐ Right foot/ankle

Other:

16. Other Restrictions (if any)

Must have latitude to alternate sitting, standing, walking as tolerable.

17. Motion Restrictions (if any):

Max hours per day	0	2	4	6	8	Other:
Walking	☐	☐	☐	☐	☐	
Climbing stairs/ladders	X	☐	☐	☐	☐	
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.

X 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
- X 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

20. Medication Restrictions (if any):

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

Part II: Work Status Information

Employee is unable to work

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): 09-01-2024

1. Injured Employee's Name: Augusta Wind	5a. Doctor's/Delegating Doctor's Name and Degree: Wiley Waites MD	5b. PA / APRN Name (if completing form): Theo Suess, APRN
2. Date of Injury: 09-01-2024 / 3. Social Security Number (last four) XXX-XX-: 0123	6. Facility Name: Any Medical Clinic	9. Employer's Name: Yard of the Month Company
4. Employee's Description of Injury/Accident: Fell into a truck at worksite with cut to right lower leg.	7. Facility/Doctor Phone and Fax Numbers: 316-262-1492 / 316-262-1493	10. Employer's Fax Number or Email Address (if known): 555-444-3210
	8. Facility/Doctor Address (Street, City, State, ZIP Code): 900 E. Mulberry Street, Whoville TX 99999	11. Insurance Carrier
		12. Carrier's Fax Number or Email Address (if known): 444-555-6789

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 10 / 02 / 2024 and is expected to continue through 11 / 02 / 2024.

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

Pain → NOT A SUFFICIENT EXPLANATION....

Part II: Work Status Information

Employee is unable to work

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): 09-01-2024

1. Injured Employee's Name: Augusta Wind	5a. Doctor's/Delegating Doctor's Name and Degree: Wiley Waites MD	5b. PA / APRN Name (if completing form): Theo Suess, APRN
2. Date of Injury: 09-01-2024 / 3. Social Security Number (last four) XXX-XX-: 0123	6. Facility Name: Any Medical Clinic	9. Employer's Name: Yard of the Month Company
4. Employee's Description of Injury/Accident: Fell into a truck at worksite with cut to right lower leg.	7. Facility/Doctor Phone and Fax Numbers: 316-262-1492 / 316-262-1493	10. Employer's Fax Number or Email Address (if known): 555-444-3210
	8. Facility/Doctor Address (Street, City, State, ZIP Code): 900 E. Mulberry Street, Whoville TX 99999	11. Insurance Carrier: Wonka Insurance Company
		12. Carrier's Fax Number or Email Address (if known): 444-555-6789

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**

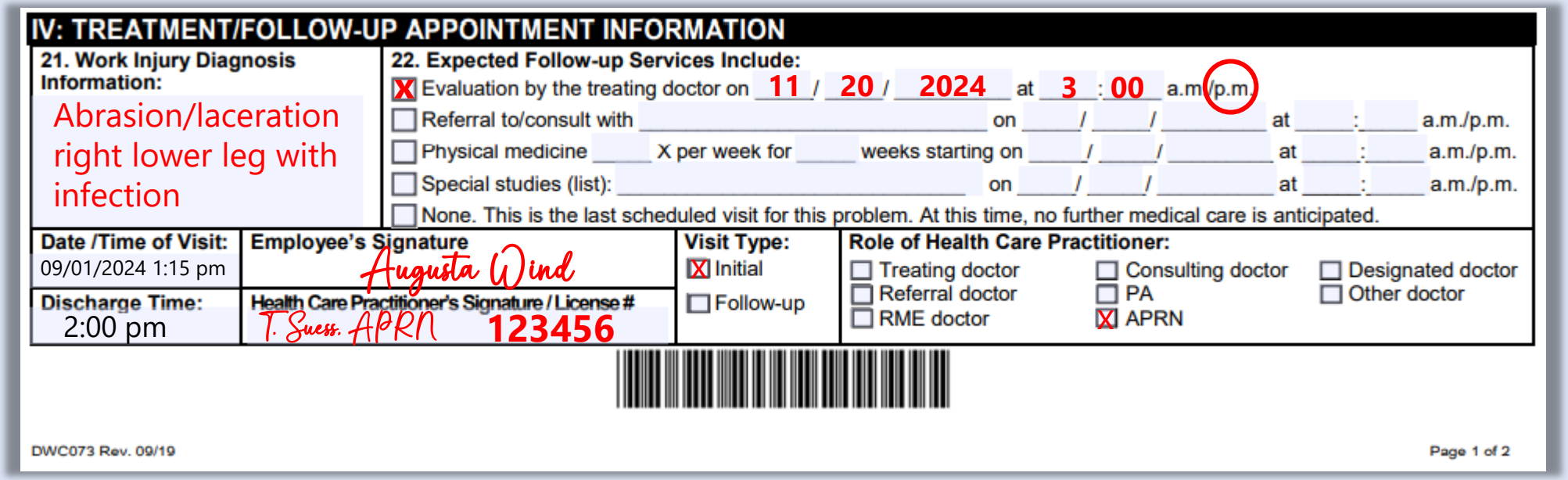
☒ **c)** has prevented and still prevents the employee **from returning to work** as of 10 / 02 / 2024 and is expected to continue through 11 / 02 / 2024.

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

Persistent abrasion/healing/ulceration right lower leg. On antibiotics for infection-confinement to minimize risk to IE and co-workers.

Part IV: Treatment and Follow-up Appointment Information

Signed by treating doctor, PA/APRN delegated by the treating doctor, referral doctor, and injured employee



IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

Abrasion/laceration right lower leg with infection

22. Expected Follow-up Services Include:

- [X] Evaluation by the treating doctor on 11 / 20 / 2024 at 3 : 00 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:
09/01/2024 1:15 pm	Augusta Wind	[X] Initial	[ ] Treating doctor [ ] Consulting doctor [ ] Designated doctor
Discharge Time:	**Health Care Practitioner's Signature / License #**	[ ] Follow-up	[ ] Referral doctor [ ] PA [ ] Other doctor
2:00 pm	T. Suess. APRN 123456		[ ] RME doctor [X] APRN

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Billing for the Work Status Report

- Bill for the Work Status Report when the rule requires the form to be completed.
- Use CPT code 99080-73 for $15.00.
- Reimbursement is due only when billed correctly and according to the rule.

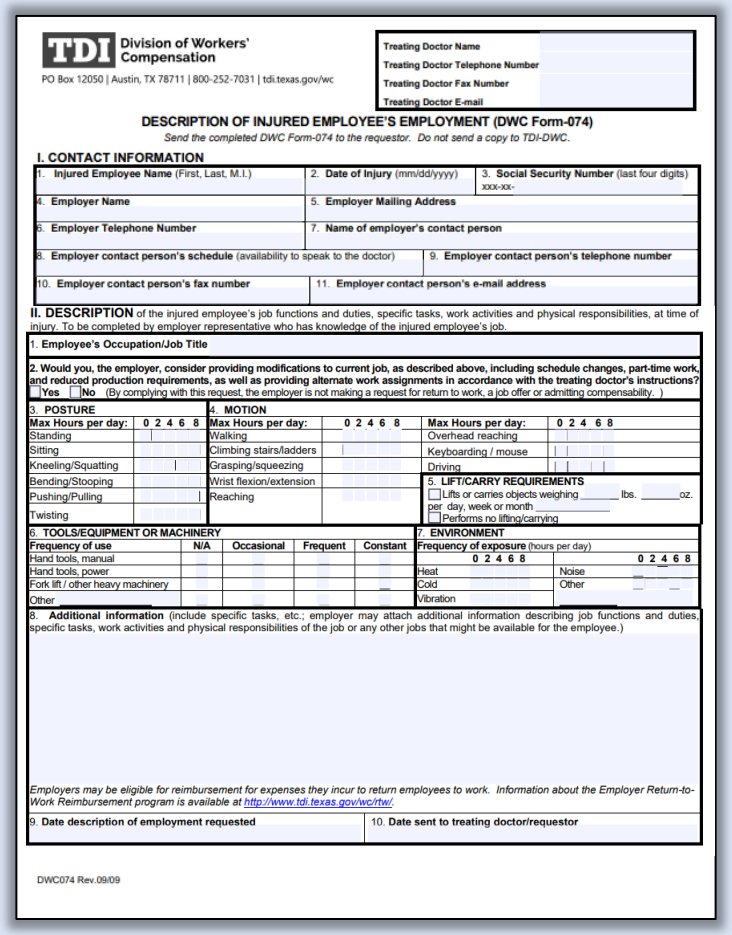
28 TAC Sec. 129.5. Work Status Report

Employer's Explanation of the Injured Employee's Job to the Treating Doctor

- Employer may assist the treating doctor by explaining the tasks and duties related to the injured employee's job.
- Employer may (not required) use the *Description of Injured Employee Employment*, DWC Form-074 to help explain:
  - Job functions and duties.
  - Specific tasks.
  - Work activities.
  - Physical responsibilities.

www.tdi.texas.gov/forms/dwc/dwc074desc.pdf

Description of Injured Employee's Employment (DWC Form-074)



TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Treating Doctor Name
Treating Doctor Telephone Number
Treating Doctor Fax Number
Treating Doctor E-mail

DESCRIPTION OF INJURED EMPLOYEE'S EMPLOYMENT (DWC Form-074)

Send the completed DWC Form-074 to the requestor. Do not send a copy to TDI-DWC.

I. CONTACT INFORMATION

1. Injured Employee Name (First, Last, M.I.)	2. Date of Injury (mm/dd/yyyy)	3. Social Security Number (last four digits) xxx-xx-
4. Employer Name	5. Employer Mailing Address	
6. Employer Telephone Number	7. Name of employer's contact person	
8. Employer contact person's schedule (availability to speak to the doctor)	9. Employer contact person's telephone number	
10. Employer contact person's fax number	11. Employer contact person's e-mail address	

II. DESCRIPTION of the injured employee's job functions and duties, specific tasks, work activities and physical responsibilities, at time of injury. To be completed by employer representative who has knowledge of the injured employee's job.

1. Employee's Occupation/Job Title

2. Would you, the employer, consider providing modifications to current job, as described above, including schedule changes, part-time work, and reduced production requirements, as well as providing alternate work assignments in accordance with the treating doctor's instructions?
☐ Yes ☐ No (By complying with this request, the employer is not making a request for return to work, a job offer or admitting compensability.)

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

4. MOTION	Max Hours per day: 0 2 4 6 8
Walking	
Climbing stairs/ladders	
Grasping/squeezing	
Wrist flexion/extension	
Reaching	

Max Hours per day:	0 2 4 6 8
Overhead reaching	
Keyboarding / mouse	
Driving	

5. LIFT/CARRY REQUIREMENTS
☐ Lifts or carries objects weighing _____ lbs. _____oz. per day, week or month _____
☐ Performs no lifting/carrying

6. TOOLS/EQUIPMENT OR MACHINERY Frequency of use	N/A	Occasional	Frequent	Constant
Hand tools, manual				
Hand tools, power				
Fork lift / other heavy machinery				
Other				

7. ENVIRONMENT Frequency of exposure (hours per day)	0 2 4 6 8		0 2 4 6 8
Heat		Noise	
Cold		Other	
Vibration			

8. Additional information (include specific tasks, etc.; employer may attach additional information describing job functions and duties, specific tasks, work activities and physical responsibilities of the job or any other jobs that might be available for the employee.)

Employers may be eligible for reimbursement for expenses they incur to return employees to work. Information about the Employer Return-to-Work Reimbursement program is available at http://www.tdi.texas.gov/wc/rtw/.

9. Date description of employment requested	10. Date sent to treating doctor/requestor

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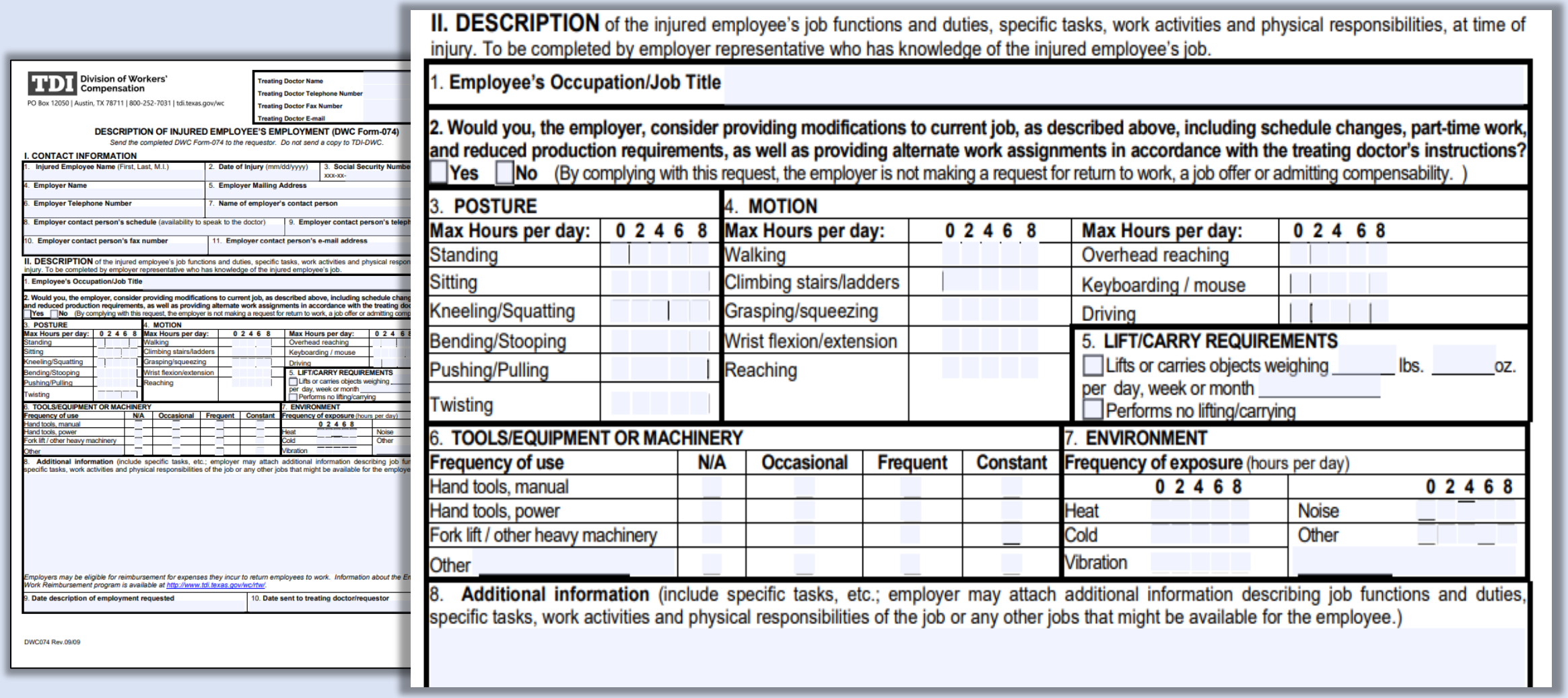
Description of Injured Employee's Employment (DWC Form-074)



TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Treating Doctor Name
Treating Doctor Telephone Number
Treating Doctor Fax Number
Treating Doctor E-mail

DESCRIPTION OF INJURED EMPLOYEE'S EMPLOYMENT (DWC Form-074)

Send the completed DWC Form-074 to the requestor. Do not send a copy to TDI-DWC.

I. CONTACT INFORMATION

1. Injured Employee Name (First, Last, M.I.) | 2. Date of Injury (mm/dd/yyyy) | 3. Social Security Number xxx-xx-
4. Employer Name | 5. Employer Mailing Address
6. Employer Telephone Number | 7. Name of employer's contact person
8. Employer contact person's schedule (availability to speak to the doctor) | 9. Employer contact person's telephone
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☐ Yes ☐ No (By complying with this request, the employer is not making a request for return to work, a job offer or admitting compensability.)

3. POSTURE

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

4. MOTION

Max Hours per day:	0 2 4 6 8
Walking	
Climbing stairs/ladders	
Grasping/squeezing	
Wrist flexion/extension	
Reaching	

Max Hours per day:	0 2 4 6 8
Overhead reaching	
Keyboarding / mouse	
Driving	

5. LIFT/CARRY REQUIREMENTS
☐ Lifts or carries objects weighing _____ lbs. _____ oz. per day, week or month _____
☐ Performs no lifting/carrying

6. TOOLS/EQUIPMENT OR MACHINERY

Frequency of use	N/A	Occasional	Frequent	Constant
Hand tools, manual				
Hand tools, power				
Fork lift / other heavy machinery				
Other _____				

7. ENVIRONMENT
Frequency of exposure (hours per day)

0 2 4 6 8	0 2 4 6 8
Heat	Noise
Cold	Other
Vibration	

8. **Additional information** (include specific tasks, etc.; employer may attach additional information describing job functions and duties, specific tasks, work activities and physical responsibilities of the job or any other jobs that might be available for the employee.)

Employers may be eligible for reimbursement for expenses they incur to return employees to work. Information about the Employer Work Reimbursement program is available at http://www.tdi.texas.gov/wc/rtw/.

9. Date description of employment requested | 10. Date sent to treating doctor/requestor

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Is there any assistance for an injured employee who may not be able to return to normal activity?

Education & Training

Employment Resources

Employment Services

Texas Workforce Commission: Vocational Rehabilitation Services

Provides services for eligible adults with disabilities to help them prepare for, obtain, retain or advance in employment.

TWC Vocational Rehabilitation Inquiries

Call: 800-628-5115

Email: customers@twc.state.tx.us.

Recap

- Goals and legislative intent.
- Support for return-to-work (RTW).
- Treating doctor and other health care practitioners' roles in RTW.
- Completing the billing for the **Work Status Report (DWC Form-73)** and the Employer's form **Description of the Injured Employee's Employment (DWC Form-074)**.

Let's flex your knowledge!

Contact Us

CompConnection:

800-252-7031 option 3

compconnection@tdi.texas.gov