

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 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	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><b>14. POSTURE RESTRICTIONS (if any):</b></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><b>17. MOTION RESTRICTIONS (if any):</b></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><b>19. MISC. RESTRICTIONS (if any):</b></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 &amp; 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><b>15. RESTRICTIONS SPECIFIC TO (if applicable):</b></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><b>18. LIFT/CARRY RESTRICTIONS (if any):</b></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><b>20. MEDICATION RESTRICTIONS (if any):</b></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><b>16. OTHER RESTRICTIONS (if any):</b></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><b>21. Work Injury Diagnosis Information:</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>22. Expected Follow-up Services Include:</b></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>				
Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up	Role of Doctor: <input type="checkbox"/> Designated doctor <input type="checkbox"/> Carrier-selected RME <input type="checkbox"/> DWC-selected RME	<input type="checkbox"/> Treating doctor <input type="checkbox"/> Referral doctor <input type="checkbox"/> Consulting doctor <input type="checkbox"/> Other doctor
Discharge Time					

