WELCOME TO WORKERS' COMPENSATION 101

Deep East Texas Self Insurance Fund

Serving Texas Since 1974

AN OVERVIEW OF BASIC WORKERS' COMPENSATION – THE PROCESS AND THE BENEFITS

PRESENTED BY:

DEEP EAST TEXAS SELF INSURANCE FUND

TIM WHITE – WHITE ESPEY, PLLC

CHRISTINE DEXTRAZE – TRISTAR RISK MANAGEMENT

WELCOME

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CE CREDIT FOR TODAY'S WEBINAR

- This webinar has been approved for 1 hour of continuing education for agents and adjuster by the Texas Department of Insurance.
- The CE course number is 127137.
- White Espey, PLLC is the CE provider for today's webinar.

AGENDA – WORKERS' COMPENSATION 101

- Reporting a Claim
- Investigation
- Medical Treatment
- Income Benefits
- Dispute Resolution
- Definitions, Terms and Acronyms
- Forms

REPORTING A CLAIM

- Employees have 30 days to notify their employer of the injury or illness
  - Notify and encourage employee to report claims as soon as possible
- Report claims to TRISTAR as soon notice as received – delays may result in fines
- Time limits for investigation and decision of compensability
- Claims are reported to TRISTAR on the DWC-1
  - Include as much information as possible
  - Contact information for the employee is critical to provide timely benefits

DWC -1 INFORMATION

- Sample DWC-1
- Employee Information
- Incident / Accident information
- Employment and Wage Information
- Employer Information

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filing.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F☐ M☐	15. Date of Injury (m-d-y) - -	16. Time of Injury : am☐ pm☐	17. Date Lost Time Began (m-d-y) - -
3. Social Security Number - -	4. Home Phone ( )	5. Date of Birth (m-d-y) - -	18. Nature of Injury*	19. Part of Body Injured or Exposed*	
6. Does the Employee Speak English? YES☐ NO☐ If No, Specify Language			20. How and Why Injury/Illness Occurred*		
7. Race White☐ Black☐ Asian☐	8. Ethnicity Hispanic☐ Native American☐ Other☐		21. Was employee doing his regular job? YES☐ NO☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
9. Mailing Address Street or P.O. Box			23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site		
City	State	Zip Code County	Street or P.O. Box	County	
10. Marital Status Married☐ Widowed☐ Separated☐ Single☐ Divorced☐			City	State	Zip Code
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury(fall, tool, machine, etc.)*		
13. Doctor's Name			25. List Witnesses		
14. Doctor's Mailing Address (Street or P.O.Box)			26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES☐ NO☐	28. Supervisor's Name / 29. Date Reported (m-d-y) - -
City	State	Zip Code			

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES☐ NO☐	32. Length of Service in Current Position Months____ Years____	33. Length of Service in Occupation Months____ Years____
34. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $____Hourly $____Weekly	37. Full Work Week is: ____Hours ____Days	38. Last Paycheck was: $____for____Hours or____Days	39. Is employee an Owner, Partner, or Corporate Officer? YES☐ NO☐

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )		43. Business Location (If different from mailing address) Number and Street	
City	State Zip Code	City	State Zip Code
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?
YES☐ NO☐ If yes, did you receive them? YES☐ NO☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

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DIVISION OF WORKERS' COMPENSATION

ADJUSTER INVESTIGATION

- It is the adjuster's responsibility to determine if the incident occurred in the course and scope of employment
- The adjuster completes the following initial steps:
  - Makes "3 point contact" with Injured Worker, Treating Physician and Employer
  - Obtains recorded statement of the Injured Worker, if indicated, witnesses, if necessary
  - Determines if there is subrogation potential (MVA, unit malfunction, no warning signs)
  - Determines compensability based on the facts
  - Reviews available medical information
  - Sets initial reserves
  - Initiates Income Benefits, if applicable

TYPES OF INJURIES AND CLAIMS

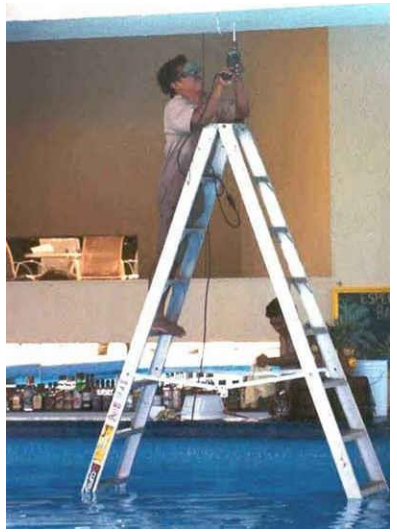
- Injuries / Illnesses
- Injury - damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.
  - Specific Injuries
    - Nature – strain, fracture, sprain, burn
    - Cause – slip, trip and fall, cut, lifting, struck by an object
  - Aggravation injuries
    - Pre-existing condition worsened by some aspect of employment.
  - Occupational Disease - a disease arising out of and in the course of employment that causes damage or harm to the physical structure including a repetitive trauma injury. The term includes a disease or infection that naturally results from the work-related disease. The term does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is an incident to a compensable injury or occupational disease.
  - Cumulative trauma
    - Condition due to repetitive activities developing over time

TYPES OF CLAIMS

- Report Only – no medical attention – no lost time
- Medical Only – medical attention but no lost time from work
  - Medical treatment may be one time visit or several visits including medication and/or physical therapy
- Lost Time (Indemnity)
  - Report ASAP – Clock is ticking
  - The day of injury does not count as a lost day
  - Must report within 8 days of injury
  - Failure to comply (Employer) is considered an Administrative Violation – subject to $500/day fine

EMPLOYEE WAGES

- Income benefits are based on an employee's Average Weekly Wage (AWW)
- The employer is required to complete the DWC-3 (Wage Statement) in order for the adjuster to determine the AWW
- Pecuniary and non-pecuniary wages are included in the AWW calculation
- The maximum and minimum compensation rate are set by the Texas Department of Insurance
- They are adjusted each year based on the State AWW as of October 1
- Currently the maximum is $1,007.00 and the minimum is $151.00



Send to workers' compensation carrier:

_____

(Name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT (DWC Form-003)

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at http://www.tdi.texas.gov/wc/rules/

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number: xxx-xx-	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:

☐ As of today's date, the employee is not back at work. **OR**
☐ The employee returned to work on _____ and is working:
☐ without restriction. **OR**
☐ with restrictions and is earning wages of $_____ per week/month (circle one).

NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

☐ **Full-time:** employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

☐ **Seasonal:** employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

☐ **Part-time: Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.

☐ **Part-time: Not Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.

☐ **Apprentice:** employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.

☐ **Minor:** employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.

☐ **Student:** employee enrolled in a course of study in high school, college or other institute of higher education or technical training.

☐ **Trainee:** employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee OR** ☐ **A Similar Employee** (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. **If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.**

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at http://www.tdi.texas.gov/wc/rules/

WAGE INFORMATION INSTRUCTIONS

Employee Name: Social Security #: Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid **to allow the employee to purchase the benefits.**

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (If suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/ Cleaning																		
Clothing/ Uniforms																		
Lodging/ Housing/																		
Food/ Meals																		
Vehicle/ Fuel																		
Other																		

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

DWC FORM-003 Rev. 10/05

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SCHOOL DISTRICT WAGE STATEMENT

- DWC-3SD
- There is a unique wage statement for school district employees
- Multiple employer wages may be combined into the employee's AWW

Send to workers' compensation carrier:

_____
(name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial
☐ Amended

EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW for a school district employee is computed based upon the wages earned in a week. "Wages earned in a week" are equal to the amount that would be deducted from an employee's salary if the employee were absent from work for one week and the employee did not have personal leave to compensate the employee for the lost wages from that week.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Workers' Compensation Rule 120.4 may be assessed an administrative penalty not to exceed $500.00 for an initial offense and not to exceed $10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes.

All applicable DWC rules can be found at http://www.tdi.texas.gov

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number: xxx-xx-	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:
☐ The employee has not returned to work. **OR** ☐ The employee returned to work on _____ ☐ without restriction. **OR** ☐ with restrictions and is earning wages of $_____ per week/month (circle one). NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.	I HEREBY CERTIFY THAT THIS WAGE STATEMENT is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules; and the listed wages include all pecuniary wages and stipends as required by statute and rule and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment. Signature: _____ Date: _____

EMPLOYMENT STATUS

Does the employee work continuously through the calendar year for the school district (i.e. does the employee work in the summer?) The answer to this question is not affected by whether the employee is paid over a 12 month period or over a shorter period.

☐ YES ☐ NO. If no, what were the dates and the number of days or months the employee was **scheduled to work** in the current school year?

From _____/_____/_____ to _____/_____/_____ which requires the employee to work _____ days OR _____ months.

☐ **WRITTEN CONTRACT EMPLOYEE:** an employee who has a written contract of employment with the school district that specifies amount that will be paid for completion of the contract and either the number of days the employee is required to work or the period of the contract. **If the employee is employed through a written contract, complete the "Written Contract Wage Information" and the "Annual Wage Information" sections on page 2.**	☐ **EMPLOYEE WITHOUT A WRITTEN CONTRACT:** ☐ **Salaried:** an "at-will", "exempt" employee paid a set salary per month/year (generally personnel staff). ☐ **Hourly:** an "at-will", "non-exempt" employee paid on an hourly basis (generally staff such as cafeteria workers, bus drivers, janitorial workers). ☐ **Daily:** an "at will" employee employed and paid on a daily basis (generally substitute teachers). ☐ **Other:** (specify) **If the employee is NOT employed through a written contract, complete the "Wage Information for Salaried, Hourly, Daily, And Other Non-Contract Employment" and the "Annual Wage Information" sections on page 2.**

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at http://www.tdi.texas.gov/wc/rules/.

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PAGE 2 WAGE INFORMATION

Employee Name: | Social Security #: | Date of Injury:

WRITTEN CONTRACT WAGE INFORMATION

Total Gross Value of Written Contract (including stipends): | Number of Work Days in Written Contract: | OR | Number of Months in Written Contract:

WAGE INFORMATION FOR SALARIED, HOURLY, DAILY, & OTHER NON-CONTRACT EMPLOYMENT

- Report the Gross Pecuniary Wages **earned in the 13 weeks immediately prior to the date of injury**. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.
- **Pecuniary Wages include all wages that are paid to the employee in the form of money**. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse travel expenses.
- If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer may not report wages earned on or after the date of injury.**
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**
- If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

The wage information in this section is from: ☐ **the Injured Employee OR** ☐ **a Similar Employee** (If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

ANNUAL WAGE INFORMATION

-Indicate the Gross Pecuniary Wages **earned in the 12 months immediately prior to the date of injury**. Include all actual money earned and paid to the employee for time off for vacation leave, sick leave and holidays but not the market value of leave time earned but not used.

- If the employee did not work for your district for one of the months indicated below, insert the letters "NE" to indicate "not employed."
- If the employee did work for your district during the month, but did not earn any wages please insert a "0".

-When setting the 12 months, you may adjust the reporting period backward up to the month prior to the date of injury to line the months up with your natural pay cycle. **Do not report wages earned on or after the date of injury**. Weekly wages may be converted to monthly wages by multiplying the gross weekly wages amount by 4.34821.

MONTH #	1	2	3	4	5	6	7	8	9	10	11	12	
FROM DATE:													
TO DATE:													TOTAL
WAGES EARNED:													

DWC FORM-3SD (Rev. 10/05) Page 2

DIVISION OF WORKERS' COMPENSATION

INCOME BENEFITS

- TIBs – temporary income benefits – 70% (or 75%) of the difference between the average weekly wage and amount earned after your work-related injury. TIBs accrue on the 8th day of lost time. Lost time may be intermittent TIBs last up to 104 weeks.
- IIBs – impairment income benefits – based on the impairment rating given by the health care provider. 3 weeks are paid for each percentage point of impairment. These benefits may be paid in addition to regular earnings but will not be paid until TIBs conclude.
- SIBs – supplemental income benefits – to qualify you must: have an impairment rating of 15% or more; have not returned to work, or if you did, have earned less than 80% of the average weekly wage in your position because of your injury; show that you are looking for work; and not accept a lump sum payment for your injury.
- The combination of TIBs, IIBs and SIBs will not exceed 401 weeks of payments.

INCOME BENEFITS

- LIBs – lifetime income benefits – LIBs may be paid based on qualifying injuries:
  - total and permanent loss of sight in both eyes;
  - loss of both feet at or above the ankle;
  - loss of both hands at or above the wrist;
  - loss of one foot at or above the ankle, and loss of one hand, at or above the wrist;
  - an injury to the spine that causes permanent and complete paralysis of both arms, both legs, or one arm and one leg;
  - a physically traumatic injury to the brain resulting in incurable insanity or imbecility;
  - third degree burns that cover at least 40 percent of the body and require grafting; or
  - third degree burns covering the majority of either both hands or one hand and the face.
  - Note: The "total and permanent loss of use" of a body part means the actual loss of that body part.

INCOME BENEFITS

- DBs – Death Benefits – paid when an employee dies because of a work-related injury or illness
  - Benefits may be paid to:
    - a surviving spouse,
    - minor children,
    - children less than 25 years old who are enrolled in an accredited college or university,
    - dependent grandchildren,
    - other dependent family members, or
    - non-dependent parents (but only when there are no surviving eligible dependent family members).
    - If no beneficiaries exist a payment is made to the Subsequent Injury Fund
- Burial Benefits – a set amount paid for some of an employee's funeral expenses to the person who paid the expenses. Up to $10,000 paid for a compensable death after 9/1/15.

RETURN TO WORK / MEDICAL TREATMENT

- The goal of medical treatment is to return the employee to their pre-injury function.
- After each medical appointment the employee will receive a DWC-73 from the medical provider.
  - In addition to medical information, this form includes work status and restrictions, if applicable.

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

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Page 1 of 2

RETURN TO WORK AND IMPAIRMENT

- Immediately report intermittent lost time.
- Immediately report when an employee returns to work.
  - Use the DWC-6 – Employer's Supplemental Report of Injury
- If the employee had been excused from work then returns to work in any capacity the DWC-6 is required or if an employee was working and becomes excused form work the DWC-6 is required.
  - Prompt completion is important to ensure the employee is properly paid any benefits that are due.

CLAIM #
Carrier #

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name
2. Employer phone #
3. Employer mailing address
4. Insurance carrier name

5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
   If so, identify contact person and phone # _____
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date _____ no ☐
7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date _____ no ☐
9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
    ☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
    ☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
    ☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name
12. SSN (last 4 digits) xxx-xx-
13. DOI
14. Injured worker mailing address and phone #
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)
16. First day of additional lost time or reduced wages (mm/dd/yyyy)
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
    If yes, the date of the 8th day (mm/dd/yyyy) _____
18. Date of most recent RTW _____
    ☐ Full duty, full pay
    ☐ Limited duty, full pay
    ☐ Limited duty, reduced pay
19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
    date of resignation _____ date of termination _____ date of death _____
    19a. Reason for resignation/termination _____
    19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐
20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week
    Indicated hours are:
    ☐ Increase from pre-injury
    ☐ Same as pre-injury
    ☐ Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of _____ to _____ : $ _____ weekly or $ _____
    Indicated wages are:
    ☐ Increase from pre-injury wage
    ☐ Same as pre-injury wage
    ☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
    Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

_____ _____
Signature and Title of person completing this form Date

DWC FORM-6 (Rev. 10/05) Page 1 DIVISION OF WORKERS' COMPENSATION

MANAGED CARE AND OTHER MEDICAL TREATMENT OPTIONS

- As medical treatment progresses, there may be other services that are required or recommended to bring the claim to a conclusion:
  - Preauthorization – medical necessity does not equal compensability. This can be confusing. Certain procedures and treatments require preauthorization. Once approved, they still must be determined to be related to the work injury.
  - Case Management – a case mangers assists in communication between the employee, the medical provider and the adjuster. They are particularly helpful in serious claims, unique claims and claims that are not progressing as expected. Not all claims are assigned a case manager.
  - Peer Reviews – used when an adjuster wants to confirm the course of treatment is reasonable an applied to the work related injury.
  - Designated Doctor – DD – a designated doctor is assigned by the Division of Workers' Compensation (DWC) at the request of the adjuster or the employee to determine MMI (maximum medical Improvement) and impairment or to offer an alternate MMI and impairment.
  - Bill Review – all medical bills are subject to the State fee guidelines established by TDI. All medical bills are reviewed, adjusted and paid in accordance with the fee guidelines.
  - ODG – Official Disability Guidelines – ODG was adopted by TDI and the guidelines for medical treatment of a workers' compensation claim. Medical providers are expected to be familiar with the ODG and treat within these parameters.

RED FLAGS

- These items may suggest to the adjuster or the employer that a more thorough investigation is necessary:
  - New employee
  - No witnesses to the incident
  - Injury claim is inconsistent with mechanics of accident
  - Discrepancy of doctor's first report vs. employee's description
  - Employees with known multiple claims
  - Injury claims following holidays or vacation
  - Monday morning or Friday claimed injuries
  - Late notification of an alleged injury
  - Discrepancy of employee's report vs. supervisor's report
  - Employees with known secondary employment
  - Injury claims with witnesses who contradict facts
  - Employees with known pre-existing conditions

DISPUTE RESOLUTION

- In the event a dispute arises regarding the compensability of a claim, extent of the injury, disability, MMI or IR or medical bill payment, or medical treatment all interested parties may go before the Division of Workers' Comp (DWC).
  - Informal dispute resolution
  - Benefit Review Conference (BRC)
  - Contested Case Hearing (CCH)
  - Appeals Panel
  - Judicial Review

FIRST RESPONDERS

- Special Rules Applicable to First Responders
  - Section 401.001(34) of the Texas Labor Code – defines occupational disease
  - Section 607.054 of the Texas Government Code – presumption for respiratory illness
  - Section 607.057 of the Texas Government Code – effect of presumption
  - Section 504.055 of the Texas Labor Code – acceleration of medical benefits for first responders
  - Recent legislative action related to COVID-19 – Senate Bill 22 (presumption) and House Bill 2073 (quarantine)

DEFINITIONS

- Compensable injury – an injury that arises out of and in the course and scope of employment for which compensation is payable.
- Course and scope – an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and this is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer. The term includes an activity conducted on the premises of the employer or at other locations.
- Disability – the inability because of a compensable injury to obtain and retain employment at wages equivalent to the pre-injury wage.
- Accrual of Income Benefits – if the disability continues for longer than one week, weekly income benefits begin to accrue on the 8th day after the date of the injury.
- Maximum Medical Improvement (**MMI**) is the earlier of:
  - The date no further material recovery from an injury is expected
  - 104 weeks from the 8th day of disability
- Impairment Rating (IR)
  - An impairment rating is the percentage of permanent impairment of the whole body resulting from a compensable injury
- Injury – damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.
- Occupational disease – a disease arising out of and in the course of employment that causes damage or harm to the physical structure including a repetitive trauma injury. The term includes a disease or infection that naturally results from the work-related disease. The term does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is an incident to a compensable injury or occupational disease.
- Repetitive trauma injury – damage or harm to the physical structure of the body occurring as the result of repetitious, physically traumatic activities that occur over time and arise out of and in the course and scope of employment.

ACRONYMS AND TERMS

- TDI – Texas Department of Insurance
- DWC – Division of Workers' Compensation
- TIBs – temporary income benefits
- IIBs – impairment income benefits
- SIBs –supplemental income benefits
- LIBs – lifetime income benefits
- DB's – death benefits
- MMI – maximum medical improvement
- IR - impairment rating
- DD – designated doctor
- RTW – return to work
- Modified Duty
- Subrogation
- BRC – Benefit Review Conference
- CCH – Contested Case Hearing

QUESTIONS

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THANK YOU

- Please be sure to complete the webinar survey that will appear immediately after the conclusion of this event.

- Keep an eye out for DETSIF's next webinar, Workers' Comp 201, which will be presented in the Fall.

DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐	15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
3. Social Security Number - -	4. Home Phone ( )	5. Date of Birth (m-d-y) - -	18. Nature of Injury*	19. Part of Body Injured or Exposed*	
6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language			20. How and Why Injury/Illness Occurred*		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐		21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
9. Mailing Address Street or P.O. Box City State Zip Code County			23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box County City State Zip Code		
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐					
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury(fall, tool, machine, etc.)*		
13. Doctor's Name			25. List Witnesses		
14. Doctor's Mailing Address (Street or P.O.Box) City State Zip Code			26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name / 29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $_____Hourly $_____Weekly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: $_____ for ___ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( ) City State Zip Code		43. Business Location (If different from mailing address) Number and Street City State Zip Code	
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

Send to workers' compensation carrier:

_____

(Name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT (DWC Form-003)

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at http://www.tdi.texas.gov/wc/rules/

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number: xxx-xx-	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:

☐ As of today's date, the employee is not back at work. **OR**
☐ The employee returned to work on _____ and is working:
- ☐ without restriction. **OR**
- ☐ with restrictions and is earning wages of $_____ per week/month (circle one).

NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

☐ **Full-time:** employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

☐ **Seasonal:** employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

☐ **Part-time: Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.

☐ **Part-time: Not Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.

☐ **Apprentice:** employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.

☐ **Minor:** employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.

☐ **Student:** employee enrolled in a course of study in high school, college or other institute of higher education or technical training.

☐ **Trainee:** employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee OR** ☐ **A Similar Employee** (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. **If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.**

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at http://www.tdi.texas.gov/wc/rules/

WAGE INFORMATION INSTRUCTIONS

Employee Name: Social Security #: Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid **to allow the employee to purchase the benefits**.

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/ Cleaning																		
Clothing/ Uniforms																		
Lodging/ Housing/																		
Food/ Meals																		
Vehicle/ Fuel																		
Other																		

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

Send to workers' compensation carrier:

_____
(name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial
☐ Amended

EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW for a school district employee is computed based upon the wages earned in a week. "Wages earned in a week" are equal to the amount that would be deducted from an employee's salary if the employee were absent from work for one week and the employee did not have personal leave to compensate the employee for the lost wages from that week.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Workers' Compensation Rule 120.4 may be assessed an administrative penalty not to exceed $500.00 for an initial offense and not to exceed $10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes.

All applicable DWC rules can be found at http://www.tdi.texas.gov

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number: xxx-xx-	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:

☐ The employee has not returned to work. **OR**
☐ The employee returned to work on _____ ☐ without restriction. **OR**

☐ with restrictions and is earning wages of $_____ per week/month (circle one).

NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT THIS WAGE STATEMENT is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules; and the listed wages include all pecuniary wages and stipends as required by statute and rule and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS

Does the employee work continuously through the calendar year for the school district (i.e. does the employee work in the summer?) The answer to this question is not affected by whether the employee is paid over a 12 month period or over a shorter period.

☐ YES ☐ NO. If no, what were the dates and the number of days or months the employee was **scheduled to work** in the current school year?

From _____/_____/_____ to _____/_____/_____ which requires the employee to work _____ days OR _____ months.

☐ **WRITTEN CONTRACT EMPLOYEE:** an employee who has a written contract of employment with the school district that specifies amount that will be paid for completion of the contract and either the number of days the employee is required to work or the period of the contract.

If the employee is employed through a written contract, complete the "Written Contract Wage Information" and the "Annual Wage Information" sections on page 2.

☐ **EMPLOYEE WITHOUT A WRITTEN CONTRACT:**

☐ **Salaried:** an "at-will", "exempt" employee paid a set salary per month/year (generally personnel staff).

☐ **Hourly:** an "at-will", "non-exempt" employee paid on an hourly basis (generally staff such as cafeteria workers, bus drivers, janitorial workers).

☐ **Daily:** an "at will" employee employed and paid on a daily basis (generally substitute teachers).

☐ **Other:** (specify)

If the employee is NOT employed through a written contract, complete the "Wage Information for Salaried, Hourly, Daily, And Other Non-Contract Employment" and the "Annual Wage Information" sections on page 2.

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at http://www.tdi.texas.gov/wc/rules/.

PAGE 2 WAGE INFORMATION

Employee Name: | Social Security #: | Date of Injury:

WRITTEN CONTRACT WAGE INFORMATION

Total Gross Value of Written Contract (including stipends):

Number of Work Days in Written Contract:

OR

Number of Months in Written Contract:

WAGE INFORMATION FOR SALARIED, HOURLY, DAILY, & OTHER NON-CONTRACT EMPLOYMENT

- Report the Gross Pecuniary Wages **earned in the 13 weeks immediately prior to the date of injury**. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

- **Pecuniary Wages include all wages that are paid to the employee in the form of money**. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse travel expenses.

- If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer may not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

- If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

The wage information in this section is from: ☐ the Injured Employee OR ☐ a Similar Employee (If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

ANNUAL WAGE INFORMATION

-Indicate the Gross Pecuniary Wages **earned in the 12 months immediately prior to the date of injury**. Include all actual money earned and paid to the employee for time off for vacation leave, sick leave and holidays but not the market value of leave time earned but not used.

- If the employee did not work for your district for one of the months indicated below, insert the letters "NE" to indicate "not employed."
- If the employee did work for your district during the month, but did not earn any wages please insert a "0".

-When setting the 12 months, you may adjust the reporting period backward up to the month prior to the date of injury to line the months up with your natural pay cycle. **Do not report wages earned on or after the date of injury**. Weekly wages may be converted to monthly wages by multiplying the gross weekly wages amount by 4.34821.

MONTH #	1	2	3	4	5	6	7	8	9	10	11	12	
FROM DATE:													
TO DATE:													TOTAL
WAGES EARNED:													

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.

CLAIM # _____
Carrier # _____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	

5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
If so, identify contact person and phone # _____ _____

6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date _____ no ☐

7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐

8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date _____ no ☐

9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN (last 4 digits) xxx-xx-	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	

17, Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
If yes, the date of the 8th day (mm/dd/yyyy) _____

18. Date of most recent RTW _____
☐ Full duty, full pay
☐ Limited duty, full pay
☐ Limited duty, reduced pay

19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
date of resignation _____ date of termination _____ date of death _____
19a. Reason for resignation/termination _____
19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐

20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week	21. Weekly/hourly earnings for the pay period of _____ to _____ : $ _____ weekly or $ _____
Indicated hours are: ☐ Increase from pre-injury ☐ Same as pre-injury ☐ Decrease from pre-injury	Indicated wages are: ☐ Increase from pre-injury wage ☐ Same as pre-injury wage ☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

_____ _____
Signature and Title of person completing this form Date

DWC FORM-6
Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
The **EMPLOYER** means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.	If you (the **INJURED WORKER)** are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.
The EMPLOYER must file this form: • **For** a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • **During** the time the injured worker is entitled to temporary income benefits (TIBs); and • **Until** the injured worker: ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer.	If you are employed by a new employer after the injury; and • You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or • You are *not* receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.

This report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with: • The insurance carrier, and • The injured worker. This report is considered filed when personally delivered or postmarked. **Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed $500.**	**This form is to be filed** by first class mail or personal delivery with: • The insurance carrier. This report is considered filed when personally delivered or postmarked. **If you return to work** for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted. **Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.**

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: http://www.tdi.texas.gov/wc/rules