Division of Workers' Compensation

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

Complete if known:
DWC Claim #
Carrier Claim #

Designated Doctor Examination Data Report

Extent of Injury, Disability, or Other Similar Issues

I. INJURED EMPLOYEE CLAIM INFORMATION

1. Employee Name (Last, First, Middle)	**2. Social Security Number** (last 4 digits) XXX-XX-
3. Insurance Carrier Name	**4. Date of Injury** (mm-dd-yyyy)

II. EXAMINATION INFORMATION

5. Designated Doctor Name	
6. Designated Doctor Mailing Address (Street or P.O. Box, City, State, ZIP Code)	
7. Designated Doctor License Number	**8. Designated Doctor License Jurisdiction**
9. Designated Doctor License Type	**10. Designated Doctor Phone Number** ( )
11. Examination Location (Street, City, State, ZIP Code)	
12. Date and Time of Appointment	

13. Does the claim involve medical benefits provided through a Certified Health Care Network?

☐ Yes ☐ No

If yes, provide the name of the network:____________________

14. Does the claim involve medical benefits provided through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool?

☐ Yes ☐ No

If yes, provide the name of the health care plan: ____________________

For DWC Use Only

III. PURPOSE OF EXAMINATION

15. Issues considered during designated doctor's examination. Check only the items that were included on DWC Form-032 and provide the requested information.

☐ **a) Extent of Injury**

Refer to the DWC Form-032 you received for this examination and provide below all the diagnoses/conditions listed in Section V, Box 36C. Did you determine that the accident or incident giving rise to the compensable injury was a substantial factor in bringing about the additional claimed diagnoses/condition, and without it, the additional diagnoses/conditions would not have occurred? Provide your answer below by checking Yes or No for each additional claimed diagnosis/condition. For data purposes only, assign the most reasonable corresponding diagnosis code(s) for each additional claimed diagnosis/condition. You may assign up to four diagnosis codes for each additional claimed diagnosis/condition. **Attach additional pages, if necessary.**

Additional Claimed Diagnosis or Condition	**Yes**	**No**	**For Data Purposes Only**			
			Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4
1)	☐	☐				
2)	☐	☐				
3)	☐	☐				
4)	☐	☐				
5)	☐	☐				
6)	☐	☐				
7)	☐	☐				
8)	☐	☐				

☐ **b) Disability - Direct Result**

Did you determine that the employee's inability to obtain and retain employment at wages equivalent to the pre-injury wage is a direct result of the compensable injury? ☐ Yes ☐ No

Refer to the DWC Form-032 you received for this examination and provide the following information as shown in Section V, Box 36D:

Provide the beginning and ending dates for the claimed periods of disability. If multiple periods, list all dates. From ______________________ to ______________________ (mm/dd/yyyy)

☐ **c) Other Similar Issues**

Refer to the DWC Form-032 you received for the examination and describe the issue(s) listed in Section V, Box 36G, and provide your response to the issue(s).

Employee's Name:

DWC Claim Number:

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IV. REFERRALS / ADDITIONAL TESTING

16. Provide the requested information regarding referrals and additional testing for this examination.

Referral Health Care Provider Name	Provider License Number	Date of Service (mm/dd/yyyy)	Type of Testing: FCE	EMG / NCV	X-Ray	MRI	CT-Scan	Psychological Testing / Evaluation	Other
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

FCE (Functional Capacity Evaluation); EMG (Electromyography); NCV (Nerve Conduction Velocity); MRI (Magnetic Resonance Imaging); CT-Scan (Computed Tomography Scan)

V. DESIGNATED DOCTOR'S SIGNATURE

17. Signature of Designated Doctor	18. Date of Signature (mm/dd/yyyy)

Frequently Asked Questions

Designated Doctor Examination Data Report
Extent of Injury, Disability, or Other Similar Issues (DWC Form-068)

Under what circumstances is DWC Form-068 filed?

DWC Form-068 must be filed when a designated doctor examination addresses issues of extent of injury, disability – direct result, or other similar issues. Do not file this form if the designated doctor examination only addressed issues of maximum medical improvement, impairment rating, and/or return to work. Title 28 Texas Administrative Code (TAC) §127.220(c) requires a designated doctor who performs an examination under §127.10(f) to file a Designated Doctor Examination Data Report in the form and manner required by DWC.

Is a narrative report required when filing DWC Form-068?

Yes. You must attach the narrative report required by Title 28 TAC §127.220, *Designated Doctor Narrative Reports*.

Where do I file DWC Form-068?

DWC Form-068, along with the narrative report, must be submitted as follows:

- Send to the treating doctor, DWC, and the insurance carrier by facsimile or electronic transmission.
- Send to the injured employee and the injured employee's representative (if any) by facsimile or electronic transmission if you have this information. Otherwise, you must send the reports by other verifiable means.

Note: With few exceptions, on your request, you are entitled to:
- be informed about the information DWC collects about you.
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html