

Complete DWC Form-069.

Page [Number]
DD Report for Injured Employee: [Injured employee name]
Date of Exam: [mm/dd/yyyy]

Impairment rating (See DWC Form(s)-069, Report of Medical Evaluation)

The exam requester asked what is the injured employee's whole person impairment on the date of MMI?

Impairment rating analysis

Expand section and add sub-headings as needed.