DD uses their business letterhead for the report.

[INSERT LETTERHEAD]

Designated Doctor Examination Narrative Report

Date: [mm/dd/yyyy]

Designated doctor name: [Name]
Designated doctor license number, type, and jurisdiction: [License number]
Designated doctor exam number: [DDNNNNN]
Exam date and time: [mm/dd/yyyy, hh:mm AM/PM]
Exam location: [Address 1, Address 2, City, State, ZIP]
Exam start time: [hh:mm AM/PM]
Exam end time: [hh:mm AM/PM]

DWC claim #: [DWC number]
Injured employee name: [Name]
Injured employee SSN (last four): XXX-XX-[NNNN]
Injured employee date of birth: [mm/dd/yyyy]
Date of injury: [mm/dd/yyyy]
Treating doctor name: [Name]
Employer name: [Name]
Insurance carrier name: [Name]
Carrier claim number: [Claim number]
Certified workers' compensation health care network or health care plan name (if any):
[Network or health care plan name]

Part 1

Only list issues ordered to be addressed by DWC.

DWC ordered me to address
List only those that apply:

- Maximum Medical Improvement
- Impairment Rating
- Extent of Injury
- Disability - Direct Result
- Return to Work
- Return to Work for Supplemental Income Benefits
- Other Similar Issues

Repeat basic claim information the header.

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

Summary of Medical History

I reviewed the medical records and other documents provided by the insurance carrier, the treating doctor, and the injured employee. (See Attachment A.)

Time spent reviewing medical history: Description of the injured employee's medical history:

Physical Exam

Exam findings: Mechanism of injury:

Insert template for additional testing and referrals, and each issue addressed, as needed.

I certify that:

- I have reviewed and approve this report.
- I have no known disqualifying association as described in 28 Texas Administrative Code Section 127.140 (relating to Disqualifying Associations) between the designated doctor (DD) and the injured employee, the injured employee's treating doctor, the insurance carrier, the insurance carrier's certified workers' compensation health care network, or a network established under Labor Code Chapter 504.
- I filed this report by verifiable means within seven working days of the exam date with DWC, or within 15 days from receiving the results of additional testing, with the injured employee, injured employee's representative (if any), treating doctor, and insurance carrier.
- I sent copies of the report to:

  The injured employee:
  [Injured Employee Name]
  [Address or Fax Number]

  The insurance carrier:

Closing information for all reports