TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Complete, if known:

DWC claim #

Insurance carrier claim #

Request for designated doctor examination

Este formulario está disponible en español en el sitio web de la División en
https://www.tdi.texas.gov/forms/dwc/dwc032sdesdoc.pdf
Para obtener asistencia en español, llame a la División al 800-252-7031.

Part 1. Injured employee information

1. Employee's name (first, middle, last)	**2. Social Security number**
3. Employee's address (street or PO box, city, state, ZIP code)	**4. Employee's county**
5. Employee's primary phone number	**6. Employee's alternate phone number**
7. Employee's date of birth (mm/dd/yyyy)	**8. Date of injury** (mm/dd/yyyy)
9. Representative's name (first, middle, last)	**10. Representative's phone number**
11. Representative's email address	**12. Representative's fax number**
13. Employer's name	**14. Employer's phone number**
15. Employer's address (street or PO box, city, state, ZIP code)	

Part 2. Insurance carrier information

16. Insurance carrier's name	
17. Insurance carrier's address (street or PO box, city, state, ZIP code)	
18. Adjuster's name (first, middle, last)	**19. Adjuster's email address**
20. Adjuster's phone number	**21. Adjuster's fax number**
22. Does the claim have medical benefits provided through a certified workers' compensation health care network? ☐ Yes ☐ No If yes, provide the name of the network.	
23. Does the claim have medical benefits provided through a political subdivision according to Texas Labor Code Section 504.053(b)(2), by 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.	

Employee's name: DWC claim number:		For DWC use only

Part 3. Treating doctor information

24. Treating doctor's name	**25. Phone number**
26. Address (street or PO box, city, state, ZIP code)	**27. Fax number**
28. License number	**29. License type**

Part 4. Designated doctor selection information

30. Check all body areas and diagnoses that apply.	**Examples (not a full list)**
☐ **Spine and musculoskeletal structures of torso** **See below for spinal cord injuries, hernia*	cervical, thoracic or lumbar regions; herniated disc; rib cage, chest wall, abdominal wall, sprains, or strains
☐ **Upper extremities** **See below for a fracture with vascular injury or a rib fracture.*	shoulder, forearm, arm, elbow, wrist, hand, finger regions, rotator cuff tear, sprains, or strains
☐ **Lower extremities (excluding feet)** **See below for a fracture with vascular injury or a pelvis fracture.*	buttock, thigh, leg, knee regions, anterior cruciate ligament (ACL) tear, meniscus tear, sprains, or strains
☐ **Feet**	toes, heel
☐ **Teeth and jaw**	temporomandibular joint (TMJ)
☐ **Eyes**	eyelid, foreign body, corneal abrasion
☐ **Other body areas or systems**	ear, nose, and throat; head and face; skin; cuts to skin involving underlying structures; non-musculoskeletal structures of the torso; hernia; respiratory; endocrine; hematopoietic; urologic
☐ **Traumatic brain injury**	concussion, post-concussion syndrome
☐ **Spinal cord injury**	spinal fracture with documented neurological injury deficit, more than one spinal fracture, cauda equina syndrome
☐ **Severe burns (including chemical burns)**	2nd, 3rd, or 4th degree; deep partial or full thickness burns
☐ **Joint dislocation, fractures with vascular injury, pelvis fractures, or multiple rib fractures**	not applicable
☐ **Infectious diseases (complicated)**	infection requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens
☐ **Complex regional pain syndrome**	not applicable
☐ **Chemical exposure**	not applicable
☐ **Heart or cardiovascular condition**	not applicable
☐ **Mental and behavioral disorders**	post-traumatic stress disorder (PTSD)

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Part 5. Purpose of examination

31. Requester: Check boxes A through G next to the issues you want the designated doctor to address and provide the requested information.

☐ **A. Maximum medical improvement (MMI) -** Has the injured employee reached MMI? If so, on what date? Statutory MMI date (if any) _____ (mm/dd/yyyy)

☐ **B. Impairment rating (IR) -** What is the injured employee's percentage of permanent impairment? MMI date* _____ (mm/dd/yyyy) (required only if Box A is **not** checked)

**The MMI date determined valid by a final DWC decision, court, or agreement of the parties.*

☐ **C. Extent of injury -** List all injuries (diagnoses, body parts, or conditions) in question, claimed to be caused by or naturally resulting from the accident or incident **and** describe the accident or incident that caused the claimed injury. The designated doctor will answer whether there was a substantial factor in bringing about the additional claimed injuries or conditions, and without it, whether the additional injuries or conditions would have not occurred.

☐ **D. Disability - direct result -** The designated doctor will answer whether the inability to obtain and retain wages equal to the pre-injury wage is due to the compensable injury. Provide the claimed period of disability. If multiple periods, list all dates.

From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐ **E. Return to work -** Is the injured employee able to return to work in any capacity and what work can the injured employee perform? Provide the period to be assessed. If multiple periods, list all dates.

From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐ **F. Return to work (supplemental income benefits) -** Has the injured employee's medical condition improved enough to allow them to return to work in any capacity for the identified qualifying periods? Provide the period to be assessed. If multiple periods, list all dates.

From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy)

☐ **G. Other similar issues -** Identify the issues for the designated doctor to address.

☐ Yes ☐ No **32. Has there been an approved DWC Form-024, *Benefit Dispute Agreement*, final DWC decision, or final court order to determine the compensable injury?**

Employee's name: DWC claim number:		For DWC use only

Part 6. Requester information

33. Check the appropriate box:

☐ **Injured employee** ☐ **Injured employee representative** ☐ **Insurance carrier**

I certify that:

- I am authorized to request the exam.
- All the information provided on this form is true and correct.
- I sent a copy of this request to all parties when I sent the original request to DWC.

I understand that any misstatement, falsification, or omission could cause an incorrect selection of the designated doctor and may result in DWC voiding any order issued.

If I am requesting this exam on behalf of the insurance carrier as their authorized agent, I certify the insurance carrier has authorized me to take all further actions and communicate with DWC about this exam request.

34. Requester's signature	
35. Requester's printed name	**36. Date of signature** (mm/dd/yyyy)
37. Requester's phone number	**38. Requester's email address**

Employee's name: DWC claim number:		For DWC use only

FAQ
Request for designated doctor examination

Who may request a designated doctor exam?
The injured employee, the injured employee's representative, or the insurance carrier may request to the Texas Department of Insurance, Division of Workers' Compensation (DWC) to order a designated doctor exam. DWC may also order a designated doctor exam on its own.

How often can a designated doctor exam occur?
A designated doctor exam may not occur more than once every 60 days. DWC may approve requests for an exam within the 60-day period if good cause exists. A designated doctor exam may occur no more than once a year after the injured employee gets eight quarters of supplemental income benefits.

Do I have to complete all the fields on the form?
Yes. If you don't provide all the required information, your request may be delayed or denied. You must specify *"No Treating Doctor"* in Box 24 if the injured employee does not have a treating doctor.

Where do I send the DWC Form-032?
Send the form to DWC by fax to 512-804-4121 or by mail to:

Texas Department of Insurance
Division of Workers' Compensation
Designated Doctor Operations
PO Box 12050, HS-DD
Austin, Texas 78711

You can also send the form electronically by creating an account in TXCOMP, DWC's claim system. See www.tdi.texas.gov/wc/txcomp for more information.

You **must** also send **a copy of the completed form to all parties** when you send it to DWC.

What does DWC do?

- If we approve the request, we will assign a designated doctor to examine the injured employee. If there is a designated doctor who was previously assigned to the claim, we will assign the same doctor if the doctor is still qualified and available. DWC will issue an order to the parties for the exam within 10 days.
- If we deny the request, we will send a notice with the specific reasons for the denial. If you want to dispute our approval or denial of a request, you are entitled to an expedited contested case hearing under 28 Texas Administrative Code Section 140.3.

Questions? Need more information?
Call us at 800-252-7031. Also, see our website at www.tdi.texas.gov/wc/dd.

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).
- 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.