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 #

Designated doctor examination data report

Extent of injury, disability, or other similar issues

Part 1. Injured employee information

1. Employee name (last, first, middle)	**2. Social Security number** (last four digits) XXX-XX-
3. Insurance carrier name	**4. Date of injury** (mm/dd/yyyy)

Part 2. Exam information

5. Designated doctor name	
6. Designated doctor mailing address (street or PO 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. Exam location (street, city, state, ZIP code)	
12. Date and time of appointment	

13. Does the claim have medical benefits provided through a certified health care network?

☐ Yes ☐ No

If yes, provide the name of the network:

14. Does the claim have medical benefits provided through a political subdivision according to Labor Code Section 504.053(b)(2), 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:

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Part 3. Purpose of exam

15. Issues considered during designated doctor's exam.

☐ **a) Extent of injury**

List all items that were included on DWC Form-032 Part 5, Box 31C and any other additional diagnoses or conditions you found to be a part of the compensable injury. 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 or condition? Provide your answer below by checking Yes or No for each additional claimed diagnosis or condition. Assign the most reasonable corresponding diagnosis codes for each additional claimed diagnosis/condition. **Attach additional pages, if necessary.**

Additional claimed diagnosis or condition	Yes	No	Diagnosis code 1	Diagnosis code 2	Diagnosis code 3	Diagnosis code 4
1)	☐	☐				
2)	☐	☐				
3)	☐	☐				
4)	☐	☐				
5)	☐	☐				
6)	☐	☐				

Additional compensable diagnoses or conditions found by the designated doctor	Diagnosis code 1	Diagnosis code 2	Diagnosis code 3	Diagnosis code 4
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 Part 5, Box 31D. Provide the beginning and ending dates for the claimed periods of disability. If multiple periods, list all dates.

From _____ to _____ (mm/dd/yyyy)

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

☐ **c) Other similar issues**

Refer to the DWC Form-032 you received for the examination and describe the issues listed in Part 5, Box 31G, and provide your response to the issues.

Part 4. Referrals and additional testing

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

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	Other
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

Functional capacity evaluation (FCE); electromyography EMG); nerve conduction velocity (NCV); magnetic resonance imaging (MRI); computed tomography scan (CT Scan)

Part 5. Signature

17. Designated doctor signature	**18. Date of signature** (mm/dd/yyyy)

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

FAQ
Designated doctor exam data report
Extent of injury, disability, or other similar issues

When do I file this form?
You must file this form when a designated doctor exam includes extent of injury, disability – direct result, or other similar issues. Do not file this form if the designated doctor exam only addressed issues of maximum medical improvement, impairment rating, or return to work-28 Texas Administrative Code (TAC) Section 127.220(c)

Is a narrative report required when filing DWC Form-068?
Yes. You must attach the narrative report required by 28 TAC Section §127.220, *Designated Doctor Narrative Reports*.

Where do I file DWC Form-068?
Send the DWC Form-068 and the narrative report to:

- The treating doctor and the insurance carrier by fax or electronic transmission.
- DWC through the designated doctor's TXCOMP profile.
- The injured employee and the injured employee's representative (if any) by fax or electronic transmission. Otherwise, send the report 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.