

LOGIN

The following instructions are for DWC form submissions via York Claims Expert (YCE). This system is web-based so you will be using the internet to access the forms. The information you see in these documents are part of our demo system. However, when you login to the system, you will see JIC in the background.

Copy and paste the following link into your favorites :

<https://www.iclaimsexpert.com/apps/ice/cow/icowlogin.r?brand=jic>

Enter your Login and Password that was provided by York Security. This is the same ID and password you will use anytime you need to access York Claims Expert.



Select: Enter a new Workers' Compensation claim and then Proceed to Claims Entry



The next screen is a reminder of what information you will need in order to open a new claim. You should then select Next to Employer Details page →



EMPLOYER DETAILS

You are now ready to enter Employer Details. Some of this information will pre-populate from your client record in YCE. Any field marked with an * (asterisk) is a required field and must be completed before moving onto the next screen.

YORK

Insured Selection | Insured Confirmation | **Employer Details** | Employee/Wage Details | Occurrence/Treatment Details | Special Assignments | Completion

For client Demo Client.

* designates required items

* Employer Location:

Country: UNITED STATES
Street: 1170 West Railroad Street
City: Long Beach State: Mississippi Zip: 39560

* Telephone: (228) 867-1387

* Jurisdiction: Texas

NAICS Code: 336412 - Aircraft Engine and Engine Parts Manufacturing

SIC Code: 3724 - Aircraft Engines and Engine Parts

Insured Report #:
Client Report #:
Location #:

* Location Coding:

Agency: 424 - Columbus
Sub Agency: 3 - Bedding
Office Location: **New Pineshit**
loan number: None Provided

Cancel | Next to Employee/Wage Details page >>

EMPLOYER WAGE DETAILS

The next screen is Employer Wage Details and includes the demographics of the injured worker. Any field with a  [drop-down] indicates there is more information available to choose from and select it to complete the form.



Insured Selection | **Insured Confirmation** | **Employer Details** | **Employee Wage Details** | Occurrence/Treatment Details | Initial Instructions | Completion

For client Demo Client.

* designates required items

* Employee ID:

* Name: is:

* Address:

* Address:

Street:

City: State: Zip:

* Telephone:

* Date of Birth:

* State of Hire:

Gender: Unknown Male Female

Marital Status: Unknown Single Married Separated Divorced Widowed

Spoken Language:

Ethnicity:

of Dependents:

Date of Hire:

* Occupation:

Insured Employee Id:

Employee Supervisor:

Employment Status:

NCCI class Code:

Wages: \$ Per: Hour Day Week Month Other:

Annual Wages: \$

days worked per week: 1 2 3 4 5 6 7

Full pay for day of injury: Yes No

Did salary continue: Yes No

OCCURRENCE/TREATMENT DETAILS

The next screen is for the Occurrence/Treatment Details. This is where you select and enter the nature, body part and cause. The sample below shows the nature fields from the drop-down:

* designates required items

Employee began work: AM PM

* Date of accident: 08/05/2015 * Time: 0:00 AM PM

* Did injury cause death: Yes No If yes, give date of death:

* Date employer notified: 08/05/2015 * Time: 0:00 AM PM

* Nature of Injury: Select Nature of Injury

For client Demo Client.

- Select Nature of Injury
- Multiple Injuries Multiple Injuries Including Both Physical and Psychological
 - Multiple Injuries Multiple Physical Injuries Only
 - Occupational Disease or Cumulative Injury AIDS
 - Occupational Disease or Cumulative Injury All Other Cumulative Injury NOC
 - Occupational Disease or Cumulative Injury All Other Occupational Disease Injury NOC
 - Occupational Disease or Cumulative Injury Asbestosis
 - Occupational Disease or Cumulative Injury Black Lung
 - Occupational Disease or Cumulative Injury Byssinosis
 - Occupational Disease or Cumulative Injury Cancer
 - Occupational Disease or Cumulative Injury Carpal Tunnel Syndrome
 - Occupational Disease or Cumulative Injury Contagious Disease
 - Occupational Disease or Cumulative Injury Dermatitis
 - Occupational Disease or Cumulative Injury Dust Disease NOC
 - Occupational Disease or Cumulative Injury Hepatitis C
 - Occupational Disease or Cumulative Injury Loss of Hearing
 - Occupational Disease or Cumulative Injury Mental Disorder
 - Occupational Disease or Cumulative Injury Mental Stress
 - Occupational Disease or Cumulative Injury Poisoning Chemical (Other Than Metals)
 - Occupational Disease or Cumulative Injury Poisoning Metal
 - Occupational Disease or Cumulative Injury Radiation
 - Occupational Disease or Cumulative Injury Respiratory Disorders
 - Occupational Disease or Cumulative Injury Silicosis
 - Occupational Disease or Cumulative Injury VDT Related Disease
 - Specific Injury All Other Specific Injuries NOC
 - Specific Injury Amputation
 - Specific Injury Angina Pectoris
 - Specific Injury Asphyxiation
 - Specific Injury Burn
 - Specific Injury Concussion

BODY PART

The next screen is the Part of Body

* Part of body:

* Cause of Injury:

* How accident occurred:

* Where accident occurred: Did injury/illness exposure occur on employer's premises: Yes No

* State of Accident:

Doing usual work: Yes No

Contact Name:

Telephone:

Select Part of Body

- Head Brain
- Head Ear(s)
- Head Eye(s)
- Head Facial Bones
- Head Mouth
- Head Multiple Head Injury
- Head Nose
- Head Skull
- Head Soft Tissue
- Head Teeth
- Lower Extremities Ankle
- Lower Extremities Foot
- Lower Extremities Great Toe
- Lower Extremities Hip
- Lower Extremities Knee
- Lower Extremities Lower leg
- Lower Extremities Multiple Lower Extremities
- Lower Extremities Toes
- Lower Extremities Upper Leg
- Multiple Body Parts (Including Body Systems and Body Parts)
- Multiple Body Parts Artificial Appliance
- Multiple Body Parts Body Systems and Multiple Body Systems
- Multiple Body Parts Insufficient Info to Properly Identify
- Multiple Body Parts No Physical Injury
- Multiple Body Parts Whole Body
- Neck Disc
- Neck Larynx
- Neck Multiple Neck Injury
- Neck Soft Tissue

FREE FORM FIELDS

This represents the last part of that section to be completed. You can enter text into the free-form fields with as much as you information as you have available. It will come through to the claims system for the adjuster review.

Equipment, materials or chemicals involved:	<input type="text"/>																														
Specific activity engaged in when occurred:	<input type="text"/>																														
Work process engaged in when occurred:	<input type="text"/>																														
Safeguards provided:	<input type="radio"/> Yes <input checked="" type="radio"/> No																														
Safeguards used:	<input type="radio"/> Yes <input checked="" type="radio"/> No																														
Witnesses:	<table border="1"><thead><tr><th>Title</th><th>First</th><th>Middle</th><th>Last</th><th>Suffix</th><th>Phone</th></tr></thead><tbody><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td></tr></tbody></table>	Title	First	Middle	Last	Suffix	Phone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>																	
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Date last worked:	<input type="text"/>																														
Date disability began:	<input type="text"/>																														
Date returned to work:	<input type="text"/>																														
Initial treatment:	<input checked="" type="radio"/> No medical treatment <input type="radio"/> Minor: by employer <input type="radio"/> Minor: by clinic or hospital <input type="radio"/> Emergency care <input type="radio"/> Hospitalized > 24 Hrs. <input type="radio"/> Future major medical / Lost Time anticipated																														
Physician/Health Care provider:	<table border="1"><thead><tr><th>Title</th><th>First</th><th>Middle</th><th>Last</th><th>Suffix</th><th></th></tr></thead><tbody><tr><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="checkbox"/></td></tr><tr><td>Country:</td><td colspan="5">UNITED STATES</td></tr><tr><td>Street:</td><td colspan="5"><input type="text"/></td></tr><tr><td>City:</td><td><input type="text"/></td><td>State:</td><td>Select State</td><td>Zip:</td><td><input type="text"/></td></tr></tbody></table>	Title	First	Middle	Last	Suffix		<input type="text"/>	<input type="checkbox"/>	Country:	UNITED STATES					Street:	<input type="text"/>					City:	<input type="text"/>	State:	Select State	Zip:	<input type="text"/>				
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Hospital:	<table border="1"><tbody><tr><td>Name:</td><td colspan="5"><input type="text"/></td></tr><tr><td>Country:</td><td colspan="5">UNITED STATES</td></tr><tr><td>Street:</td><td colspan="5"><input type="text"/></td></tr><tr><td>City:</td><td><input type="text"/></td><td>State:</td><td>Select State</td><td>Zip:</td><td><input type="text"/></td></tr></tbody></table>	Name:	<input type="text"/>					Country:	UNITED STATES					Street:	<input type="text"/>					City:	<input type="text"/>	State:	Select State	Zip:	<input type="text"/>						
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[← Back to Employee/Wage Details page](#) [Cancel](#) [Next to Special Instructions page →](#)

SUBMITTING

This is the final screen to be completed. In the section "Send first report of injury to": You can enter your e-mail address and the DWC-1 will be forwarded to you. You can also add other people to this list and they will receive the DWC-1. However, the e-mail will come via York so you may want to consider e-mailing the information to yourself to then forward. If you check the box next to the e-mail address then it will always send the DWC-1 to those addresses. Therefore, it is recommended that you not check this box but simply leave your name in that field.

YORK

Insured Selection Insured Confirmation Employer Details Employee/Wage Details Occurrence/Treatment Details **Special Instructions** Completion

For client Demo Client.

Almost finished! Please tell us if you have any special instructions. These items are not shown on the first report of injury.
* designates required items

* Send first report of injury to:
Note: You may enter multiple email addresses separated by commas

Contact me first: Check this box to alert the adjuster to contact you prior to any investigation.

Any message for the adjuster:

Would you like an investigator involved:

This is your last chance, press "Cancel" now if you want to abandon this claim opening. Otherwise, press "Next to Completion page" to submit the claim and generate the first report of injury.

← Back to Occurrence/Treatment Details page Cancel Next to Completion page →

This is the claim number that will be assigned to the claim (note it is a 7-digit number in the sample below as 5685542). You now have three options: (1) Open another claim; (2) Log out; or (3) Enter iClaims Expert if you want to submit a DWC-3 or DWC-6 form.

YORK

Insured Selection Insured Confirmation Employer Details Employee/Wage Details Occurrence/Treatment Details Special Instructions **Completion**

For client Demo Client.

Thank you for completing this report! Please make a note of the claim number. The adjuster should be making their contacts shortly.

Your ICE claim number is: **5685542**

The first report of injury? will be emailed to: susan.mullins@yorkrsg.com

The claim has been assigned to: David M Richard
(985) 624-6750
David.Richard@fara.com

Press "Open another Claim" to repeat this process and open another claim.
Press "Log Out" to end this session.
Press "Enter iClaimsExpert" to continue into ICE with your current login.

? You'll need a PDF reader to view your first report of injury. If you don't have one, you can get it [here](#) 

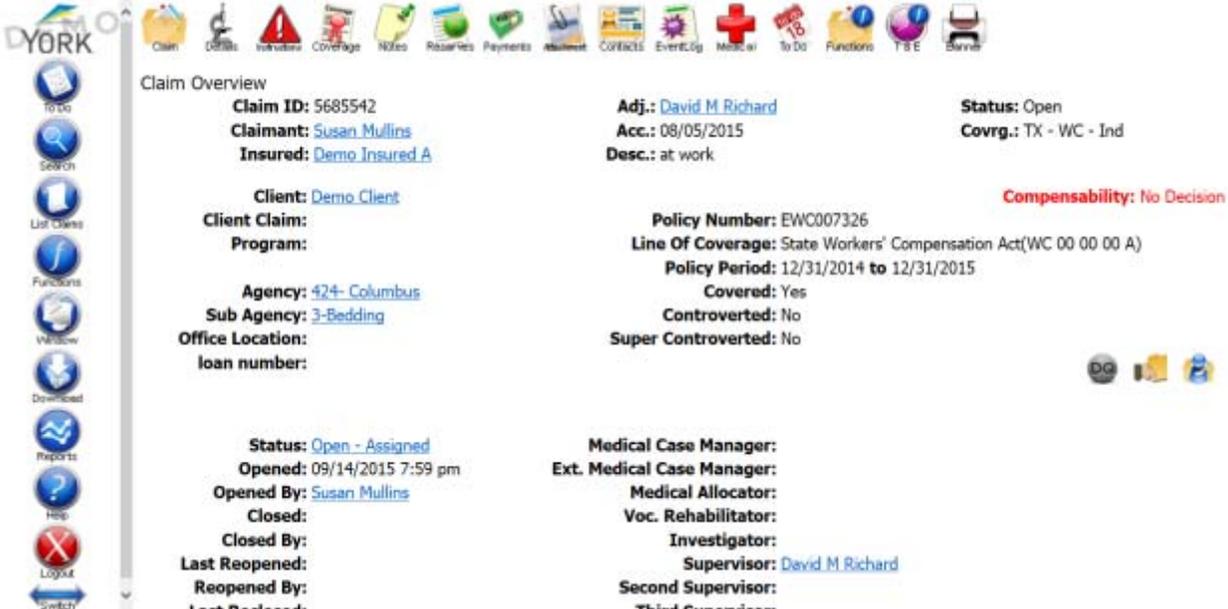
Your first report of injury will be emailed shortly from info@iclaimsexpert.com. Please ensure that your email service does not block incoming emails from this address.

Open another Claim Log Out Enter iClaimsExpert

DWC FORM 3 AND DWC FORM 6

If you choose to enter a DWC form (3 or 6) and select that option, this is the screen you will be taken to.

Select the  button at the top of the screen to go to the module for the DWC forms.



Claim Overview

Claim ID: 5685542	Adj.: David M Richard	Status: Open
Claimant: Susan Mullins	Acc.: 08/05/2015	Covrg.: TX - WC - Ind
Insured: Demo Insured A	Desc.: at work	
Client: Demo Client		Compensability: No Decision
Client Claim:	Policy Number: EWC007326	
Program:	Line Of Coverage: State Workers' Compensation Act(WC 00 00 00 A)	
	Policy Period: 12/31/2014 to 12/31/2015	
Agency: 424- Columbus	Covered: Yes	
Sub Agency: 3-Bedding	Controverted: No	
Office Location:	Super Controverted: No	
loan number:		
Status: Open - Assigned	Medical Case Manager:	
Opened: 09/14/2015 7:59 pm	Ext. Medical Case Manager:	
Opened By: Susan Mullins	Medical Allocator:	
Closed:	Voc. Rehabilitator:	
Closed By:	Investigator:	
Last Reopened:	Supervisor: David M Richard	
Reopened By:	Second Supervisor:	

Once you are in the function module, go to the Miscellaneous section and select "Forms and Letters". You may not see all of these options on your security set up so don't be alarmed.

This screen will show the name of the person who submitted the DWC-1, the Unit Manager at York and if the claim has been assigned, the adjuster. You can check the Action box to notify any of those individuals you have submitted the form. **We request you select both the Unit Manager and Adjuster.**

Title (optional)	Name (optional)	Email	Action
User Opened By	Susan Mullins	susan.mullins@jcompar	Include: <input type="checkbox"/>
Adjuster Supervisor	David M Richard	David.Richard@fara.com	Include: <input type="checkbox"/>

You should only see Texas forms available. You can enter the form you want to use by entering it in the search field or what appears on the screen in Forms and Letters. We will work on the DWC-3 first.

DWC FORM 3

Name	LOB	State
DWC-3 - Employer's Wage Statement	All LOB Codes	Texas
DWC-3 School Districts - Employer's Wage Statement for School Districts	All LOB Codes	Texas
DWC-32 - Request for Designated Doctor	All LOB Codes	Texas
DWC-32 Spanish - Solicitud para Obtener un Examen por Parte de un Medico Designado	All LOB Codes	Texas
DWC-3ME Multiple Employment Wage Statement	All LOB Codes	Texas

(Page 1 of 1)

The DWC-3 form comes up as a typeable PDF. There are highlighted fields for you to complete but all of the injured workers' demographics will populate from the claim that was set up. Any changes to the address or other key areas will automatically update to this form so if changes were made between the submission of the DWC -1 and the DWC-3 (or DWC-6) then that information updates to the demographics on the forms.

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records.

CLAIM # 5695542
CARRIER'S CLAIM # 5695542

Initial Amended **EMPLOYER'S WAGE STATEMENT**

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of this form is to provide the employer's wage information to the carrier for calculating the employer's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 402.051(a) and Workers' Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$200.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed") means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the outset of:

(A) the employer's eighth day of disability;

(B) the date the employer is notified that the employee is entitled to income benefits;

(C) the date of the employee's death as a result of a compensable injury;

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (only when requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWRC rules can be found at www.tdlr.state.tx.us.

EMPLOYEE AND EMPLOYER INFORMATION	
Employee's Name (Last, First, MI): Mullins, Susan	Employer's Business Name: Dermo Insured A
Employee's Mailing Address (Street or P.O. Box): 88 Maple St	Employer's Mailing Address (Street or P.O. Box): 1170 Wavel Railroad Street
City: Aurora TX ZIP Code: 78757	City: Long Beach MS ZIP Code: 39565
Social Security Number: 888-88-6789	Federal Tax ID Number: 646000749
Date of Hire: 10/01/2014	Date of Injury: 08/05/2015

As of today's date, the employee is not back at work. OR
 The employee returned to work on _____ and is working
 without restriction. OR
 with restrictions and is earning wages of \$ 0.00 per
 week/ month (check one).

NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWRC FORM-8) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned) in the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a worker's compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

The next screenshot below is the section to enter wages and hours. Note, there are drop down options for the dates and provides you with a calendar you can use to select your dates or you can free-form type in the text. Also note the wages will total on the right side of the form.

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records.

WAGE INFORMATION INSTRUCTIONS Employee Name: Mullins, Susan Social Security #: xxx-xx-6788 Date of Injury: 08/05/2015

The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34521. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting boundaries with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers.

PRICUNARY WAGE INFORMATION Pricunary Wages include all wages that are paid to the employee in the form of money. These include but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; long-term disability compensation; monetary allowances; bonuses and commissions. Earnings are reported in the periods they are earned. NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pricunary wages shall include payments made by an employer to reimburse the employee for the use of the employer's equipment or for paying taxes or to reimburse for travel expenses. Consider an amount earned from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	TOTALS
FROM DATE:														
TO DATE:														
# HOURS WORKED:														
GROSS WAGES EARNED:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

NONPRICUNARY WAGE INFORMATION Nonpricunary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or payments paid to allow the employee to purchase the benefits.

Benefit Type	Employer Provided Prior To Injury?		Specify Value or Amount Earned in Each Reporting Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Did Employer Continue To Provide?		Rate Recalled (If Suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance		<input checked="" type="checkbox"/>																<input checked="" type="checkbox"/>
Laundry/Cleaning		<input checked="" type="checkbox"/>																<input checked="" type="checkbox"/>
Clothing/Medicals		<input checked="" type="checkbox"/>																<input checked="" type="checkbox"/>
Laundry/Housing		<input checked="" type="checkbox"/>																<input checked="" type="checkbox"/>
Food/Meals		<input checked="" type="checkbox"/>																<input checked="" type="checkbox"/>
Vehicle/Fuel		<input checked="" type="checkbox"/>																<input checked="" type="checkbox"/>
Other		<input checked="" type="checkbox"/>																<input checked="" type="checkbox"/>

Once you complete the form you select the "submit" button to save the form to the system as an attachment. It becomes part of the claim file.

DWC FORM 6

You will see some of the same functionality with the DWC-6 forms. The same notification screen, same option to select or search for the form.

DWC-6

Associated With: Claim
 Document Type: All +
 Search Options: [Refresh Listing](#)

Form/Letter History
 Sorry, no form/letter history available.

Forms and Letters
DWC-6 - Supplemental Report of Injury

Attachment Options
 Attach PDF to Claim: 5685542

Email Options

Title (optional)	Name (optional)	Email	Action
User Opened By	Susan Mullins	susan.mullins@jicompar	Include: <input type="checkbox"/>
Adjuster Supervisor	David M Richard	David.Richard@fara.com	Include: <input type="checkbox"/>

[Add Email](#)

[Back](#) [Request Form](#)

DWC-6

Associated With: Claim
 Document Type: All +
 Search Options: [Refresh Listing](#)

Form/Letter History
 Sorry, no form/letter history available.

Forms and Letters

Name	LOB	State
DWC-6 - Supplemental Report of Injury	All LOB Codes	Texas
Texas DWC-6		
DWC-69 - Report of Medical Evaluation	All LOB Codes	Texas
Texas DWC-69		

(Page 1 of 1)

As with the DWC-3 form, the DWC-6 is also a PDF that you can type data directly on to and will prepopulate the demographics of the injured worker. Don't forget to select the "submit" button.

Please fill out the following form. You cannot save data typed into this form.
Please print your completed form if you would like a copy for your records.

Highlight Existing Fields



CLAIM #	
Carrier # 5685542	

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name Demo Insured A	2. Employer phone # 2288671367
3. Employer mailing address 1170 West Railroad Street, Long Beach, MS 39560	
4. Insurance carrier name Self-Insured	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone #	
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> Date <input type="text"/> no <input type="checkbox"/>	
7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> Date <input type="text"/> no <input type="checkbox"/>	
9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10.	<input type="checkbox"/> a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days. <input type="checkbox"/> b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days. <input type="checkbox"/> c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days. <input type="checkbox"/> d. The injured worker resigned or was terminated from employment. File within 10 days.
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Part III INJURED WORKER INFORMATION

11. Injured worker name Susan Mullins	12. SSN XXX-XX-6789	13. DOI 08/05/2015
14. Injured worker mailing address and phone # 88 Maple St, Austin, TX 78757, 5128889999		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	

Please fill out the following form. You cannot save data typed into this form.
Please print your completed form if you would like a copy for your records.

Highlight Existing Fields

17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? If yes, the date of the 8 th day (mm/dd/yyyy)		yes <input type="checkbox"/> no <input type="checkbox"/>
18. Date of most recent RTW <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay	19. Has the injured worker resigned, been terminated or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____	
	19a. Reason for resignation/termination	
	19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____ hours per week	21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____	
Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury	Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same as pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage	

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: Employer Injured Worker (if no longer working for the employer where injury occurred)

Signature and Title of person completing this form _____ Date _____



DWC FORM-6 (Rev. 10/05) Page 1 DIVISION OF WORKERS' COMPENSATION