Doctor's First Report of Occupational Injury Or Illness

Online System User Manual

Version 3.0

07/16/2025

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1. Introduction

Welcome to the Doctor's First Report of Occupational Injury or Illness (DFR) online system. The system allows a physician who treats an injured worker to register and electronically file a Doctor's First Report of Injury (DFR) with the Division of Workers' Compensation (DWC). Currently, physicians file a complete DFR with the employer's claims administrator. The claims administrator then sends a paper copy of the DFR by mail to the Department of Industrial Relations (DIR). The online system allows for standardized data to be filed and submitted directly to DWC.

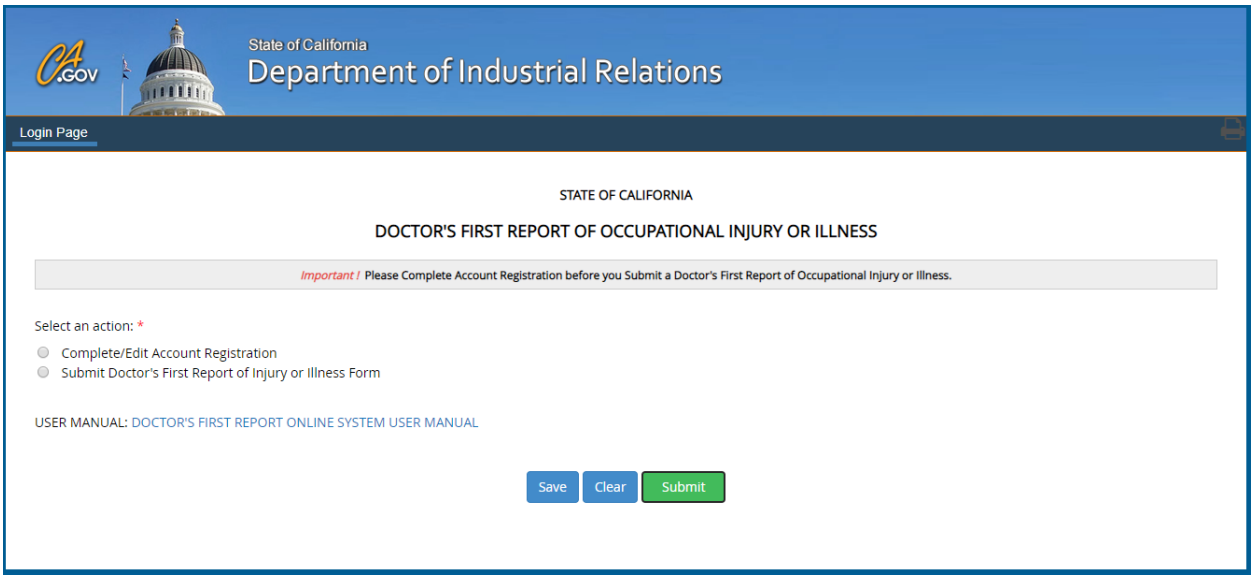
The following are some general rules for using the DFR online system:

- Access to the DFR online system is available to authenticated users only.
- Users will need to contact DIR via email to obtain a URL to access DFR online system.
- The physician's license number and email address will be used for account login identification.
- DFR online system will allow users to create and maintain their account.
- Users will have the ability to register up to five specialties.
- Users will have the ability to enter multiple medical office locations.

2. Overview

The DWC Doctor's First Report of Injury online system allows users to create new accounts or edit an existing account, and submit a DFR report form.

- When users access the DFR online system, a login page is displayed.



- To create or edit an account profile, click on the **Complete/Edit Account Registration** button. You will only need to create an account profile the first time you access the system. User account information will be saved and will automatically populate a DFR being filled out.

- To submit a DFR, click on **Submit Doctor's First Report of Injury or Illness Form** on the login page. Fill out the form, then click **Submit**.

2.1 Form Navigation

- Click **Save** to save your information.
- Click **Clear** to clear the screen without saving your information.
- Click **Back** to go back to the previous screen.
- Warning or error messages will display if any fields are missing or in an incorrect format. You may then make corrections to the data. Click **Submit** to submit your completed form.

NOTE:
The **Save** button allows you to save your entries on a form without submitting it.
To submit a completed form, you must click the **Submit** button.

2.2 Cautions & Warnings

- To prevent data loss, save your document frequently
- Do not click on the browser refresh icon. It will clear any unsaved data.
- Once the **Submit** button is clicked, the document cannot be edited.

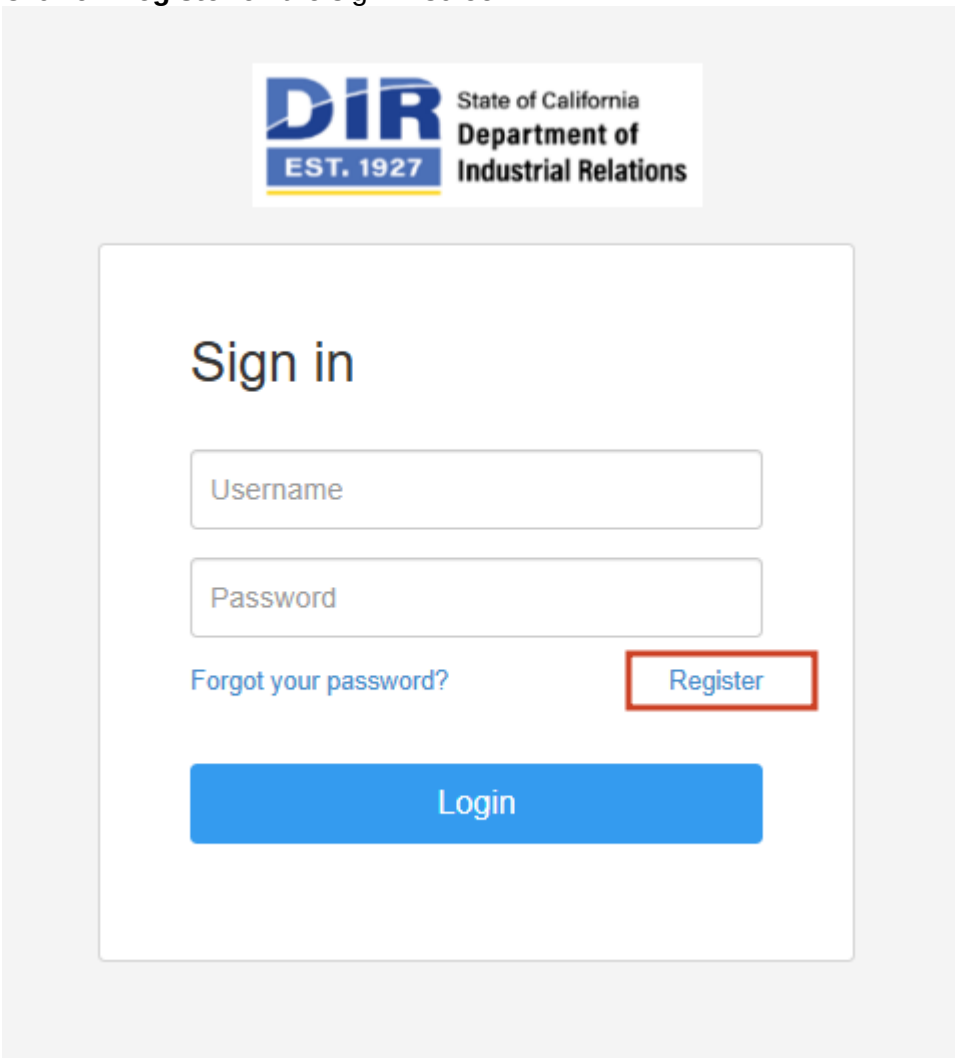
3. Entering and Exiting the System

3.1 Getting Started

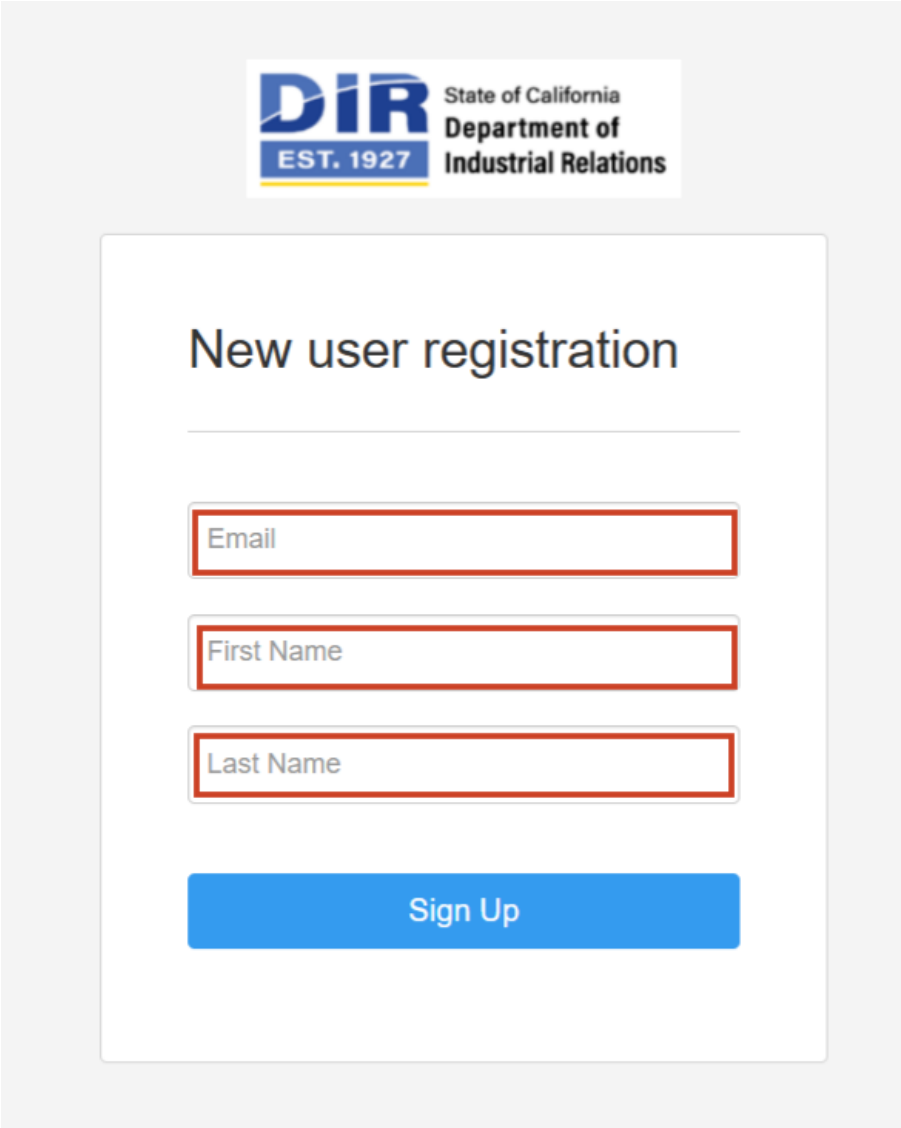
Access to the DFR online system is available to authenticated users only. Please contact DIR via email to obtain a URL with which to access DFR online system. Once you have received the URL and accessed the login page, follow the **three** steps below.

1. Account Registration:

- Click on **Register** on the sign in screen

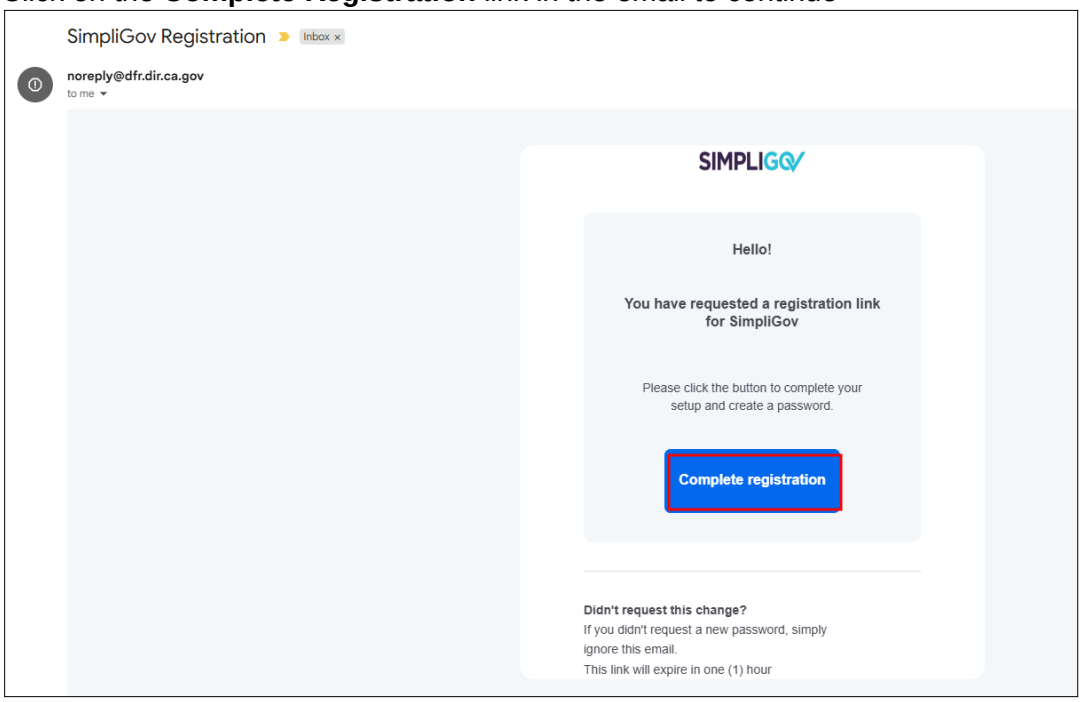


- Enter your **Email** (this will be your username), **First Name** and **Last Name,** then click on **Sign Up**

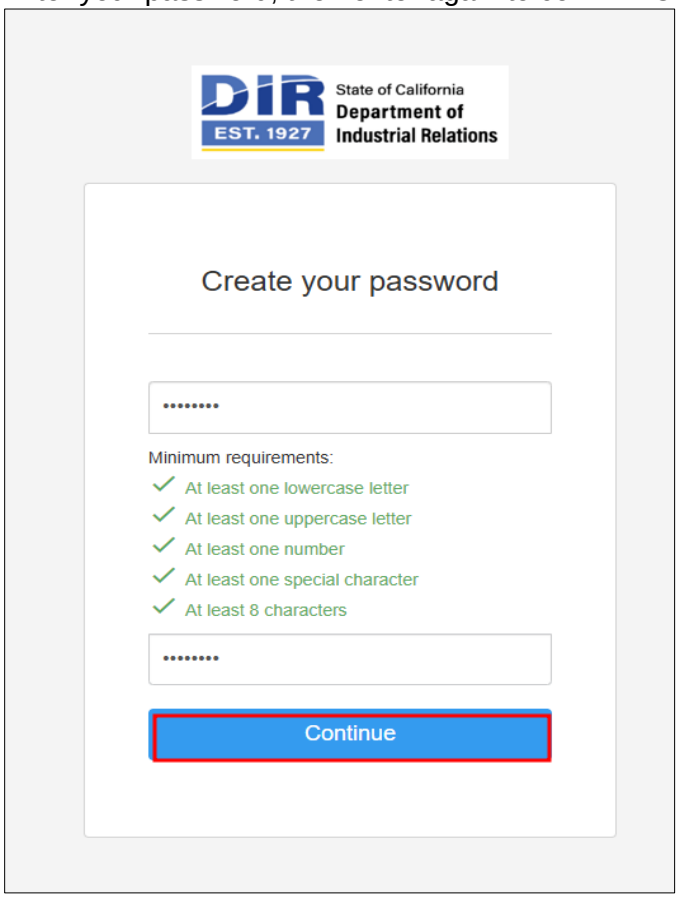


A notification email with instructions to complete account registration will be sent to your email address

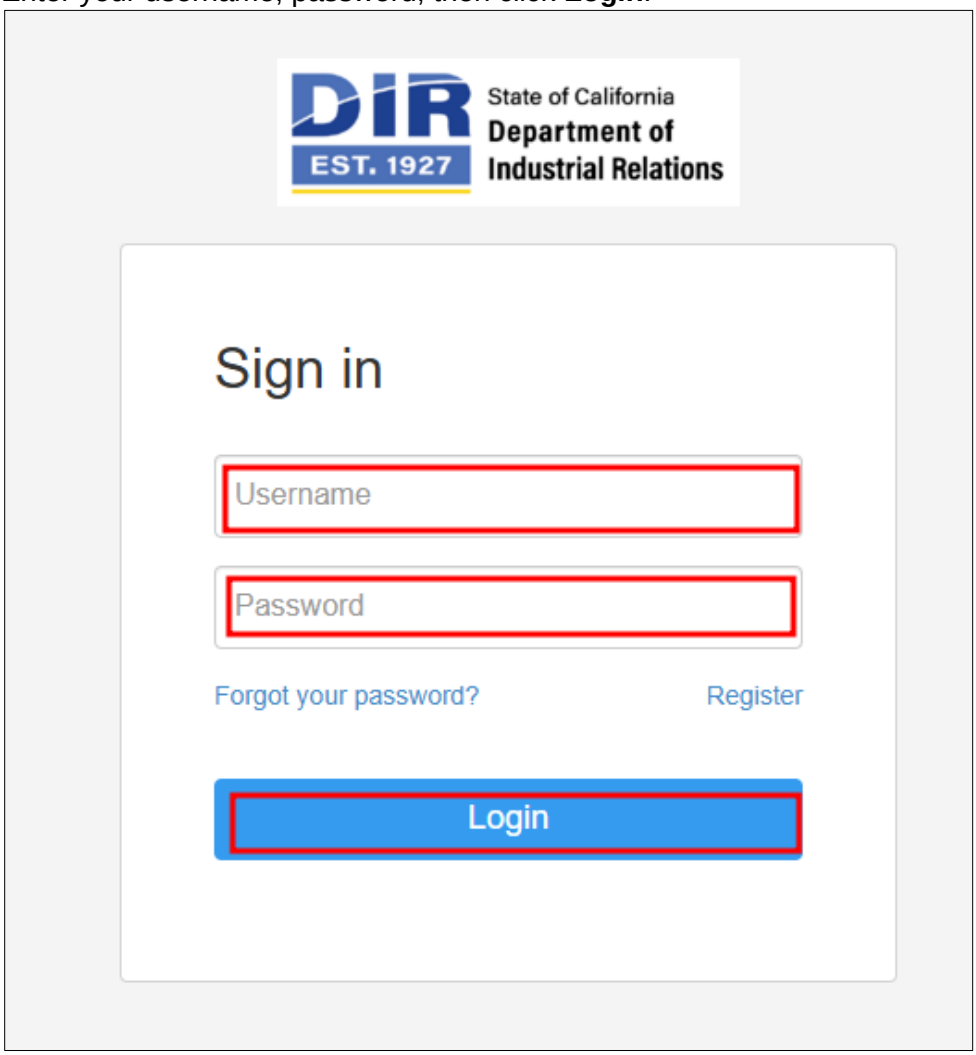
- Click on the **Complete Registration** link in the email to continue



- Enter your password, then enter again to confirm. Click **Continue.**

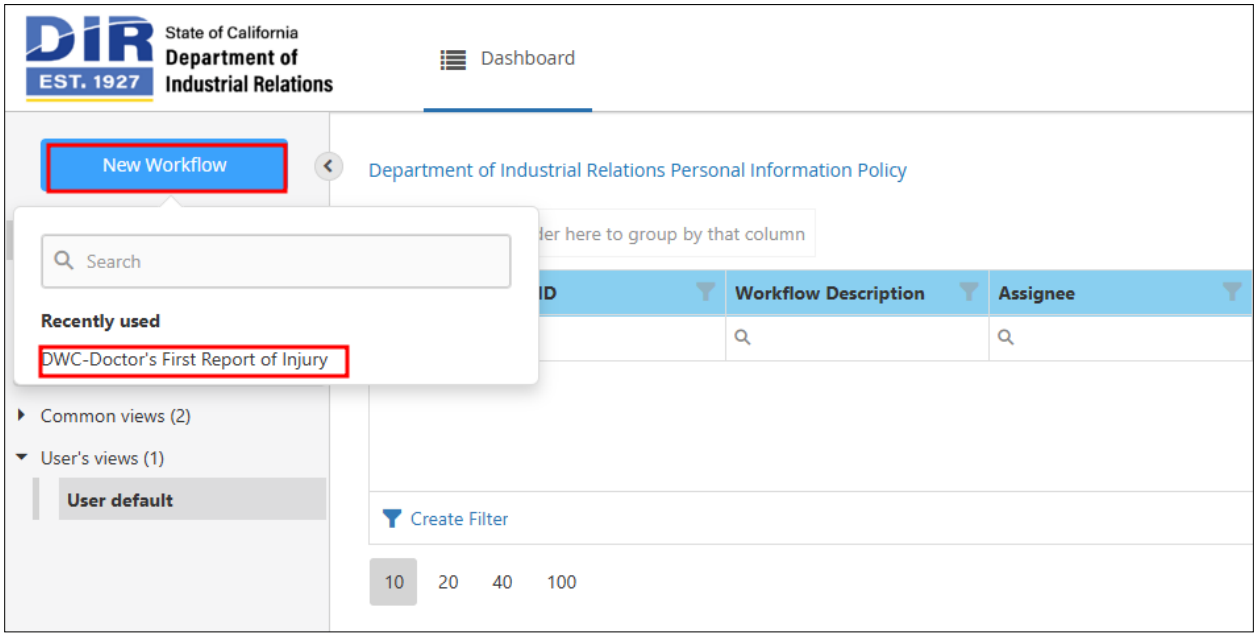


- Enter your username, password, then click **Login**.

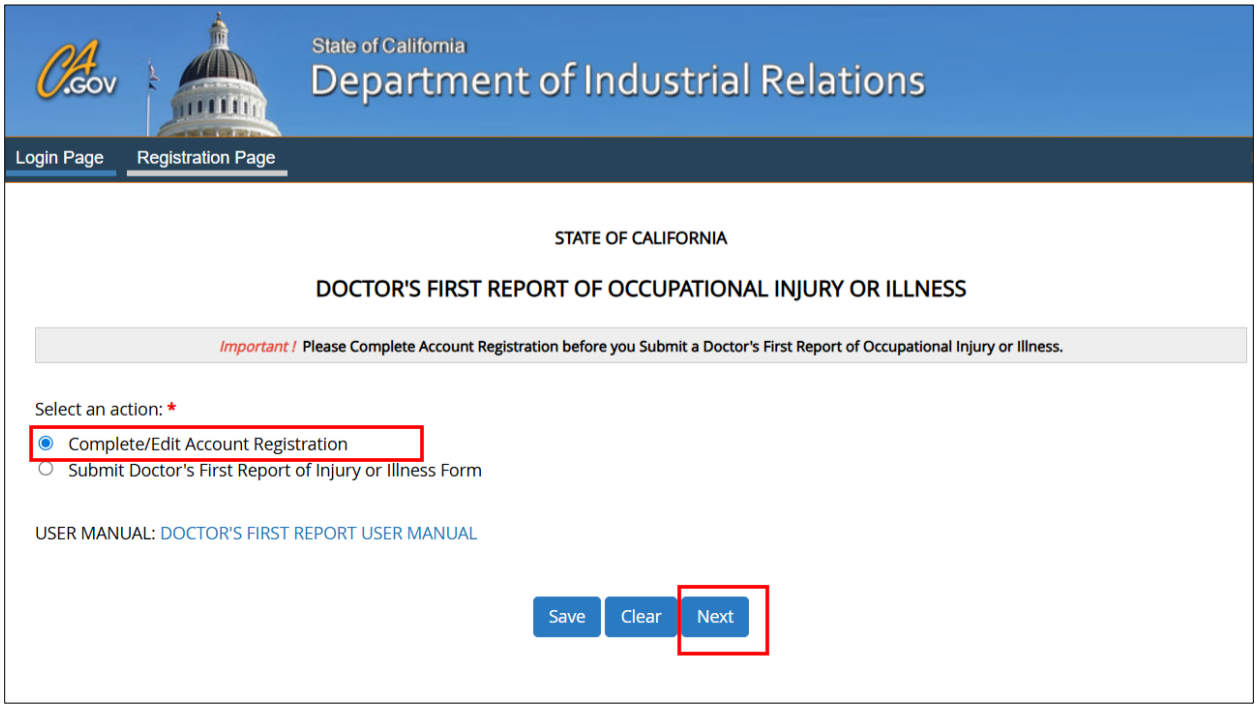


2. Complete Account Profile:

- Click on the **New Workflow** box on the top left side of the screen and select **DWC-Doctor's First Report of Injury** in the drop-down menu.



- This will open the DFR login page. To create your account profile, select **Complete/Edit Account Registration** and click **Next** to fill out the form.

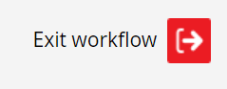


3. Submit Doctor's First Report Form:

- To submit a DFR, go to the login page and select **Submit Doctor's First Report of Injury or Illness Form** and click **Next** to start filling out the form. You can click on the Instructions link on top of the form for instructions on how to complete the Doctor's First Report. In addition, pop-up tooltips provide more information appear when you hover over each field. Click **Submit** when you have completed the form.

3.2 Exit the workflow

To exit the system, click the Exit workflow button on the right top of the screen.

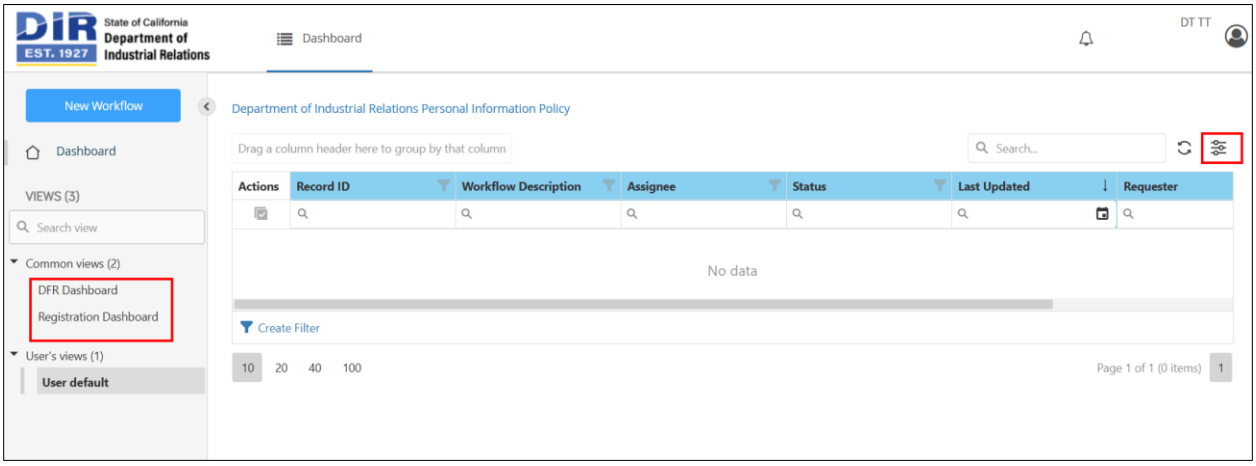


4. Using the System

4.1 Workflow Dashboard

The Workflow Dashboard displays when you initially access the DFR online system. The **New Workflow** menu to the left of the Workflow Dashboard shows available workflow templates. Select **DWC-Doctor's First Report of Injury** to access the DFR online system.

- Three **Views** are available:
    - **Registration Dashboard** filter displays your DFR Registration workflows
    - **DFR Dashboard** filter displays your Doctor's First Report submissions
    - **User Default** is the system default filter that displays all workflows.
- You can further customize the Dashboard by clicking on this icon above the workflow records area on the right. Click **Select Columns**. The Select Columns pop-up will appear, listing all currently displayed columns. Click **x** next to a column to delete it from the display list.
- To add a column, use the drop-down to search for columns you would like to add. Click **Add** and then **Save**.



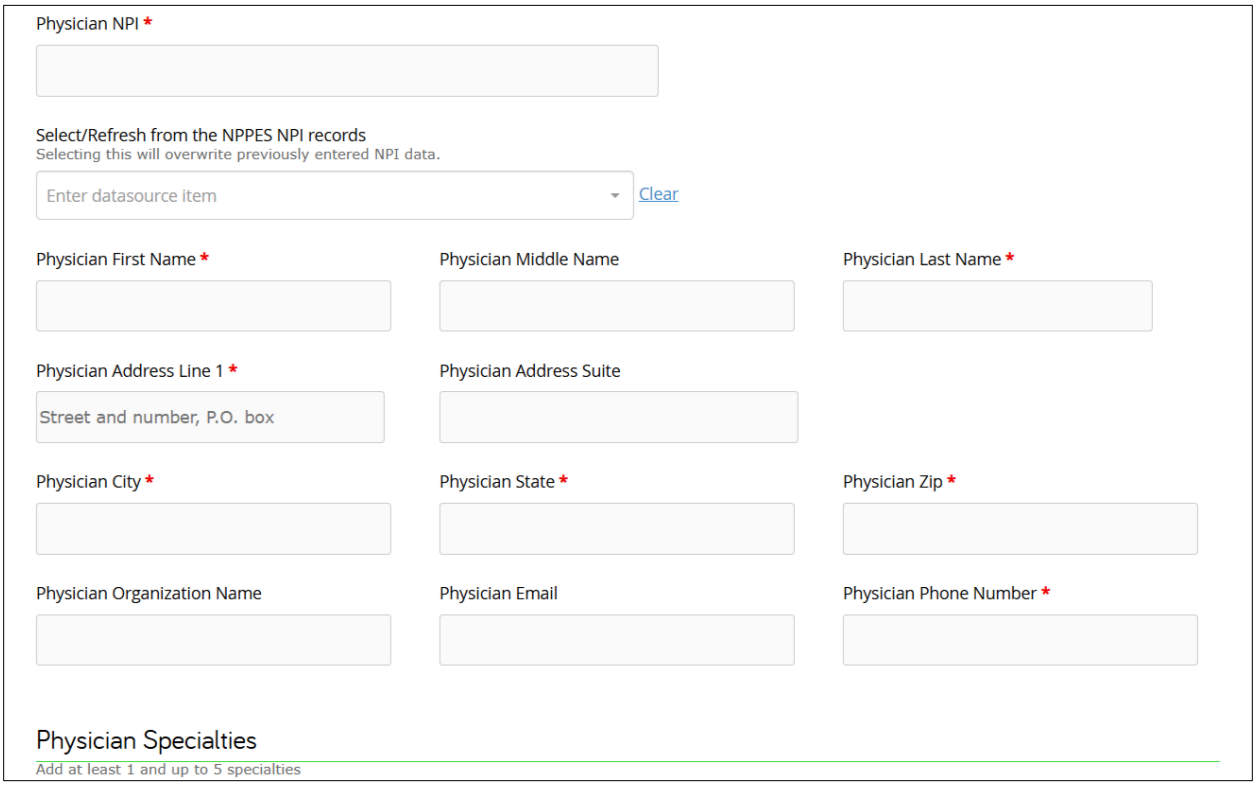
4.2 Filling out the Physician Profile

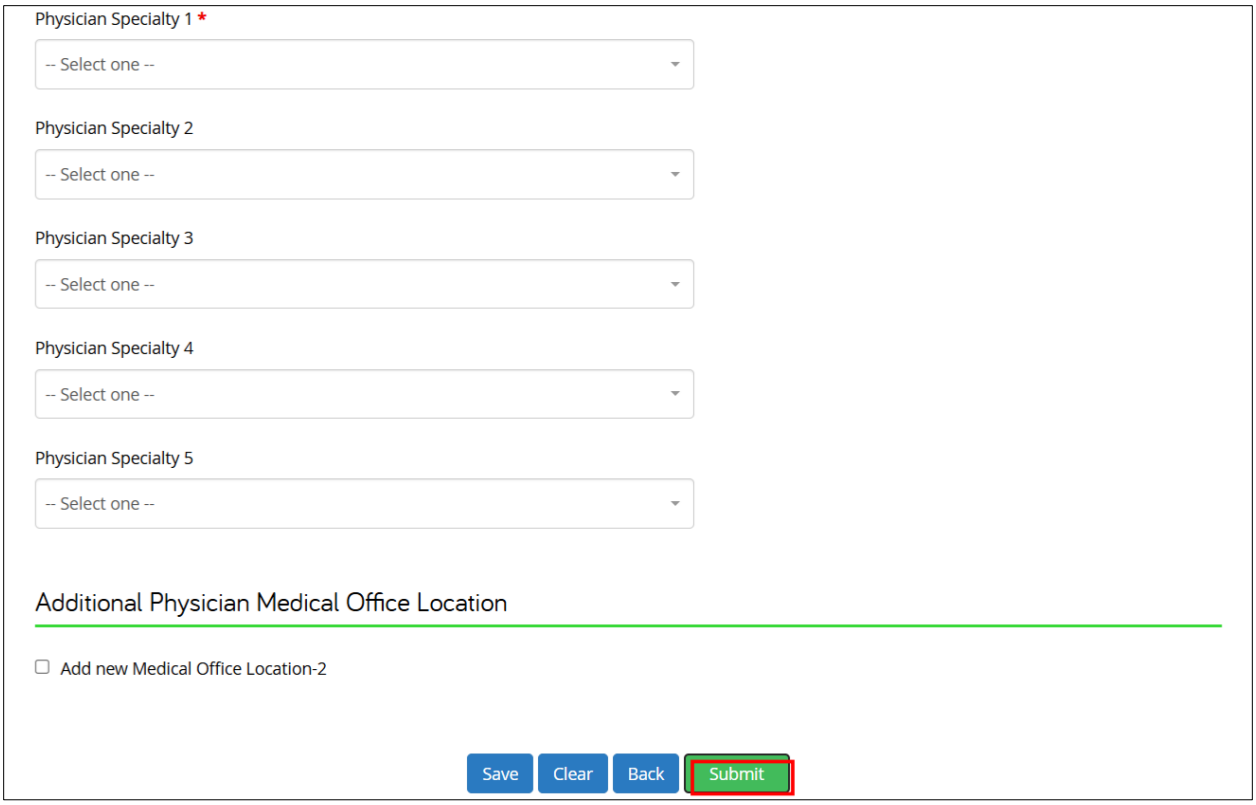
On the first page of Doctor's First Report, select action **Complete/Edit Account Registration** to fill out the Physician Profile form.

The Registration form will display as below:

Select **Create a New Account/Registration**, fill out all the fields and click **Submit**.

State of California
Department of Industrial Relations
Login Page
Registration Page
STATE OF CALIFORNIA
DOCTOR'S FIRST REPORT REGISTRATION
Welcome: Test User
ttvu60@yahoo.com
Instructions: Completing the Doctor's First Report Registration Form
Select an action: *
Create a New Account/Registration
Modifying an Existing Registration
Physician Information
License Number *
Physician License State *
CA


Physician NPI *
Select/Refresh from the NPPES NPI records
Selecting this will overwrite previously entered NPI data.
Enter datasource item
Clear
Physician First Name *
Physician Middle Name
Physician Last Name *
Physician Address Line 1 *
Street and number, P.O. box
Physician Address Suite
Physician City *
Physician State *
Physician Zip *
Physician Organization Name
Physician Email
Physician Phone Number *
Physician Specialties
Add at least 1 and up to 5 specialties



Follow these instructions to complete the Registration Page.

- **Select an action** - Click on Create a New Account/Registration or Modifying an Existing Registration.
- **License Number** – Enter the physician license number. The field can contain letters, numbers and spaces and must not exceed 30 characters.
- **Select an account to modify** – Click on the box. If the license has been previously registered, the physician details will come up and all the appropriate fields will be populated once you click on the physician details result.
- **Physician License State** – The state of the primary physical location of your business entity. Please note that the field must contain two-character, standard state abbreviation letters.
- **Physician NPI** – Enter the physicians' National Provider Identification number. The number entered will be validated against the NPI database and the physician NPI data will be retrieved and populated into the following fields.
- **Physician License State** – Select the appropriate two-character abbreviation.

- **Physician NPI** – Enter the Physician's National Provider Identification number. This is a unique 10-digit identification number and will be validated against the NPI database.

- **Select/Refresh from the NPPES NPI records** – Click on the data retrieved from the drop-down list to
place the selected data into this field. This will also automatically populate the data into appropriate fields for Physician's Name and Address.

- **Physician Organization Name** – Enter the organization name corresponding to the Master Federal Employer's Identification Number (FEIN) of your business entity. The field can contain letters, numbers, spaces and special characters (except the vertical bar or pipe character "|") and must not exceed 300 characters.

- **Physician Email** – Enter the email of the primary physical location of your business entity.

- **Physician Phone Number** – Enter the ten-digit phone number of the primary physical location of your business entity.

- **Physician specialty_1…5** – Select the physician specialty from the drop-down list. Click on "Add new specialty 2" checkbox to add another specialty. Select up to five specialties.

- **Physician Office 2…5 Address Look-up Tool** – Click on "Add new Medical Office Location-2" checkbox to add a new location and start typing the street address on "Physician Office 2 Address Look-up Tool-2". The matching address will come up and populate into appropriate address fields. Enter up to five Medical Office locations.

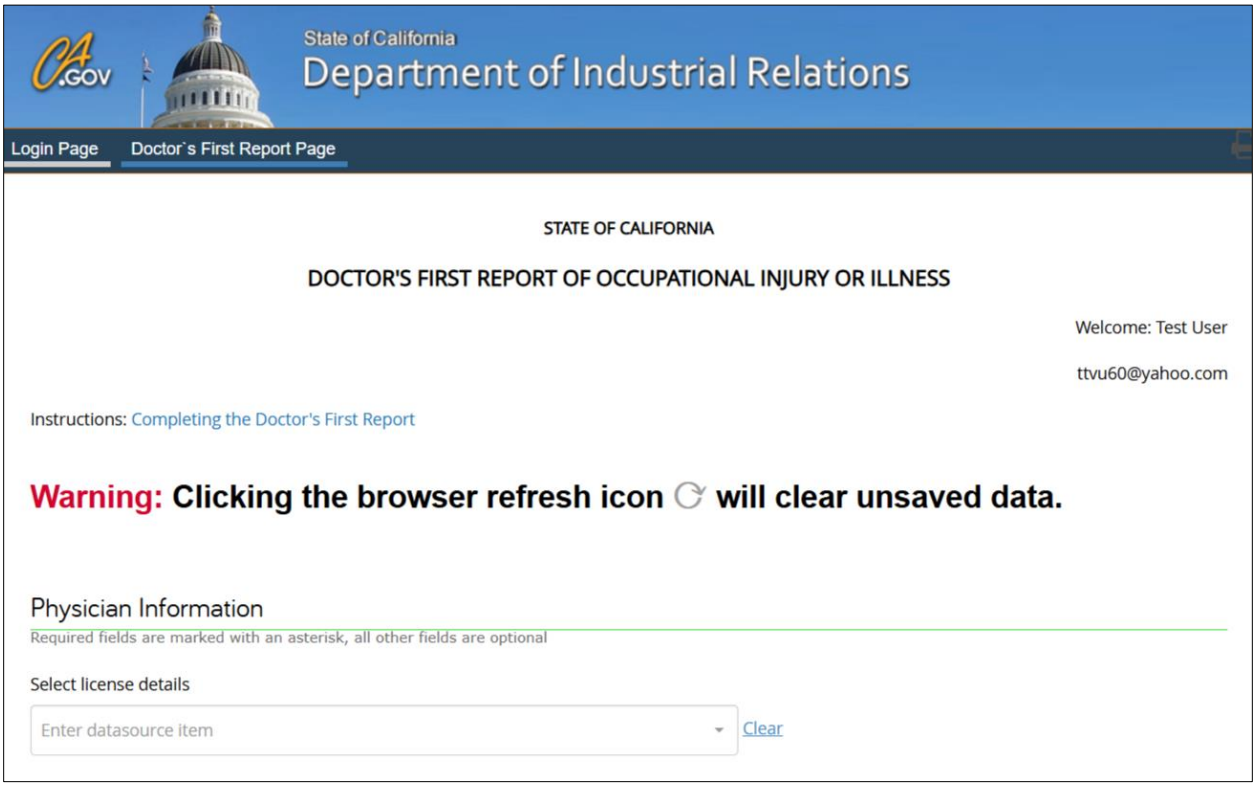
- Click the "**Submit**" button at the end of the page to submit your account registration.

4.3 Filling out the Doctor's First Report form

At the login page, click **Submit new Doctor's First Report Form (DFR)** to go to Doctor's First Report Page.

Note: Doctor's First Report Form cannot be updated after submission.

The Doctor's First Report Page screen will display:



License Number: *

NPI

License State *

Insurer Information

Required fields are marked with an asterisk, all other fields are optional

1. Insurer Name *

2. Self-Insured? *

○ Yes ○ No

Insurer Address Look-up *

Address selected will populate the address fields below

Start typing and select

3. Insurer Address (No. and Street) *

Street and number, P.O. box

4. Insurer Suite

5. Insurer City *

6. Insurer State *

7. Insurer Zip *

Claim Administrator Information

Required fields are marked with an asterisk, all other fields are optional

8. Same as Insurer?

○ Yes ○ No

9. Claim Administrator Name

Claim Administrator Address Look-up

10. Claim Administrator Address (No. and Street)

Street and number, P.O. box

11. Claim Administrator Suite

12. Claim Administrator City

13. Claim Administrator State

14. Claim Administrator ZIP

Employer Information

Required fields are marked with an asterisk, all other fields are optional

15. Employer Name *

Employer Address Look-up *
Address selected will populate the address fields below

Start typing and select

16. Employer Address (No. and Street) *

Street and number, P.O. box

17. Employer Suite

18. Employer City *

19. Employer State *

20. Employer Zip Code *

21. Nature of Business *
(e.g. food manufacturing, building construction, retailer of women's clothes.)
Enter "Unavailable" if unknown

22. Industry

-- Select one --

Patient Information

Required fields are marked with an asterisk, all other fields are optional

23. Patient First Name *

24. Middle Initial

25. Last Name *

26. Sex *

○ Female ○ Male ○ Other

This field is required

27. Date of Birth *

MM/dd/yyyy

Patient Address Look-up *
Address selected will populate the address fields below

Start typing and select

28. Patient Address *

Street and number, P.O. box

29. Patient Suite/Apartment

30. Patient City *

31. Patient State *

32. Patient Zip Code *

33. Patient Cell Phone

34. Patient E-mail Address

35. Social Security Number

36. Patient Height (inches)

37. Patient Weight (lbs)

38. Patient Preferred Language

-- Select one --

39. Occupation (Specific Job Title) *
Enter "Unavailable" if unknown

40. Does Provider have Patient's Essential Functions/Job Description? *

○ Yes ○ No

Injury Information

Required fields are marked with an asterisk, all other fields are optional

Injury Location Address Look-up *
Address selected will populate the address fields below

Start typing and select

42. Injury Street Address *

Street and number

43. Injury Location Suite/Apartment

44. City Where Injury Occurred

45. State where Injury Occurred *

46. ZIP where Injury Occurred *

47. Injury County *

48. Date of Injury or Onset of Illness *

MM/dd/yyyy

49. Hour of Injury or Onset of Illness *
24-hour time format. HH:MM

00:00

50. Cumulative Injury? *

- Yes
- No

This field is required

51. Nature of Injury *

-- Select one --

52. Nature of Accident *

-- Select one --

53. Date Last Worked *

MM/dd/yyyy

54. Date of 1st Exam or Treatment *

MM/dd/yyyy

55. Hour of 1st Exam or Treatment *
24-hour time format. HH:MM

00:00

56. Have you or your office previously rendered treatment? *

- Yes
- No
- Unknown

This field is required

57. Patient's Description of Accident or Exposure *

Assessment

Required fields are marked with an asterisk, all other fields are optional

58. Subjective Complaints *

59. Objective Findings

A. Physical Examination *

B. X-ray and Laboratory Results

Diagnoses (if occupational/work related illness specify etiologic agent and duration of exposure.)

60. Chemical/Toxic Substance/Pesticide Involved? *

○ Yes ○ No ○ Unknown

California laws and regulations require physicians and other licensed health care professionals to report any known or suspected case of pesticide-related illness or injury to the Local County Health Officer within 24 hours. More information available at https://oehha.ca.gov/pesticides/pesticide-illness-surveillance-pesticide-illness-reporting

☐ 62. Add ICD_10 - 1

74. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? *

○ Yes ○ No ○ Unknown

This field is required

76. Is there any other current condition that will impede or delay patient's recovery? *

○ Yes ○ No

This field is required

78. Treatment Rendered *

79. Is further treatment required? *

○ Yes ○ No

This field is required

81. Has the patient been hospitalized as a result of this visit? *

○ Yes ○ No

This field is required

Work Status

90. Is patient able to perform usual work? *

○ Yes ○ No ○ Unknown

This field is required

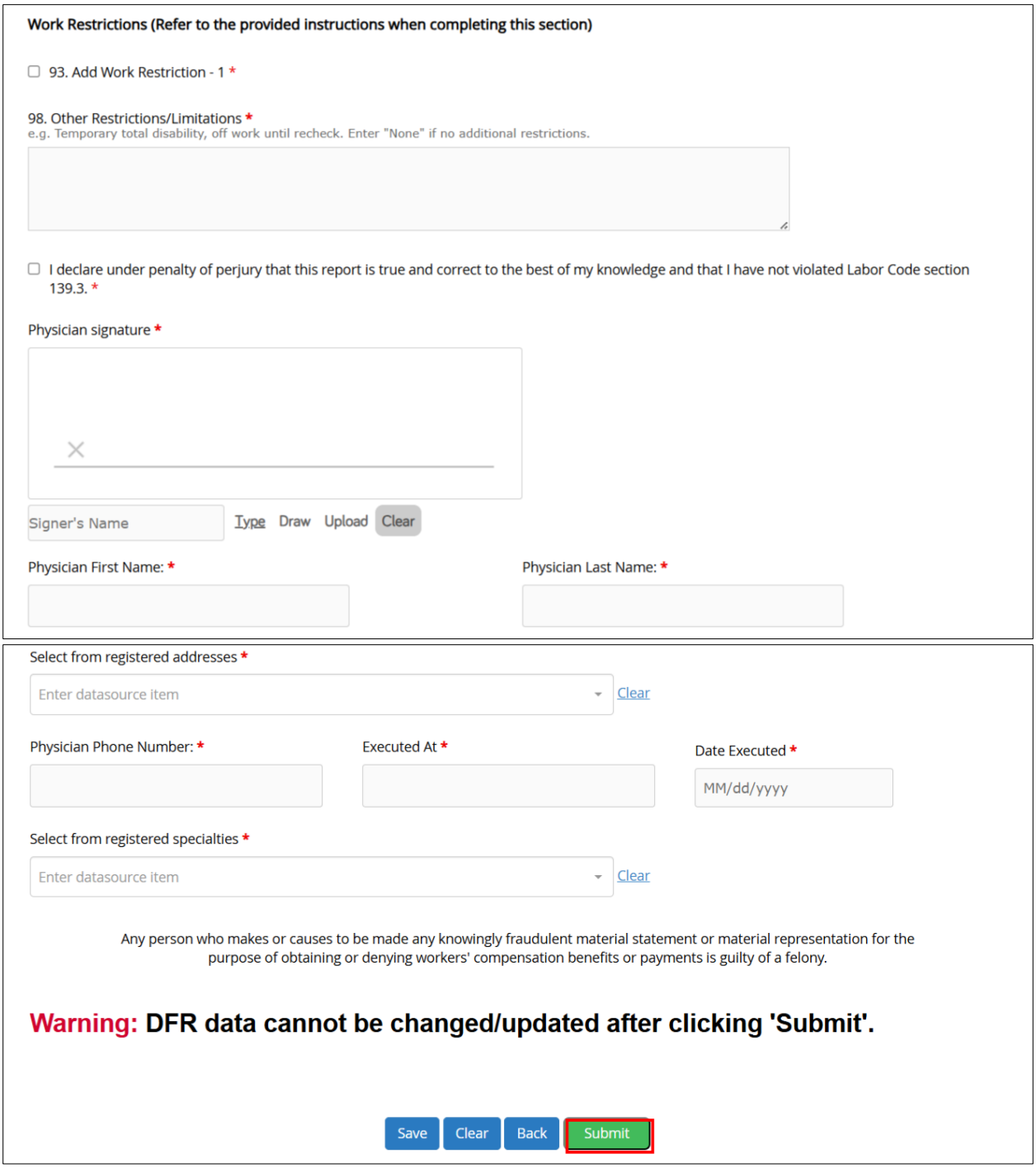
Date when patient can return to:

91. Modified work

MM/dd/yyyy

92. Regular work

MM/dd/yyyy


Work Restrictions (Refer to the provided instructions when completing this section)
93. Add Work Restriction - 1 *
98. Other Restrictions/Limitations *
e.g. Temporary total disability, off work until recheck. Enter "None" if no additional restrictions.
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3. *
Physician signature *
Signer's Name
Type
Draw
Upload
Clear
Physician First Name: *
Physician Last Name: *
Select from registered addresses *
Enter datasource item
Clear
Physician Phone Number: *
Executed At *
Date Executed *
MM/dd/yyyy
Select from registered specialties *
Enter datasource item
Clear
Any person who makes or causes to be made any knowingly fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.
Warning: DFR data cannot be changed/updated after clicking 'Submit'.
Save
Clear
Back
Submit

Follow these instructions to complete the Doctor's First Report.

Instructions for Completing the Doctor's First Report

Physician Information:

Select license details – Click on the box, then select the registered license number. It will place the selected data into this field and automatically populate "License Number" and "NPI" fields.

License Number – Auto-Populating

NPI – Auto-Populating

License State – Auto-Populating

Insurer/Claim Administrator/Employer Information

Insurer Name – Enter the insurer name. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 60 characters.

Self-Insured? – Select from radio button list Yes or No.

Insurer Address Look-up – Enter the insurer address. As you type the street number, a drop down list will appear. Select the address you want, it will place the selected data into this field. It will also automatically populate the data into appropriate boxes for Insurer Address, Insure City, Insurer State, and Insurer Zip.

Same as Insurer? – Select from radio button list Yes or No.

Claim Administrator Name - Enter the claim administrator name. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 60 characters.

Claim Administrator Address Look-up – Enter the claim administrator address. As you type the street number, a drop down list will appear. Select the address you want, it will place the selected data into this field. It will also automatically populate the data into appropriate boxes for Claim Administrator Address, City, State, and Zip code.

Employer Name - Enter the insurer name. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 60 characters.

Employer Address Look-up – Enter the employer address. As you type the street number, a drop down list will appear. Select the address you want, it will place the selected data into this field. It will also automatically populate the data into appropriate boxes for Employer Address, City, State, and Zip code.

Nature of Business – Enter the industry to which a company belongs (e.g. food manufacturing, building construction, retailer of women's clothes, etc.). The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 60 characters.

Industry – Select from the drop down list.

Patient First Name – Enter the patient first name. The field must not exceed 35 characters.

Middle Initial – Enter one letter initial of the patient middle name if applicable.

Last Name - Enter the patient last name. The field must not exceed 60 characters.

Sex – Select from radio buttons.

Date of Birth – Enter patient Date of Birth. Select from a dropdown calendar.

Patient Address Look-up - Enter the patient address. As you type the street number, a drop down list will appear. Select the address you want, it will place the selected data into this field. It will also automatically populate the data into appropriate boxes for Patient Address, City, State, and Zip Code.

Address – Auto-poulating

Phone Number – Enter the patient ten-digit phone number.

Occupation – Enter the patient job title. The field must not exceed 60 characters.

Social Security Number – Enter the patient SSN with dashes. For example, enter 123-45-6789.

Injury Location Address Look-up – Enter the location where injury occurred. As you type the street number, a drop down list will appear. Select the address you want, it will place the selected data into this field. It will also automatically populate the data into appropriate boxes for Address, City, and County where Injury occurred.

Address No. & Street Where Inj. Occurred – Auto-populating.

Date of Injury or Onset of Illness – Enter the date when injury occurred. Select from a dropdown calendar. Date of Injury must be greater than Date of Birth and less than Current Date.

Hour of Injury or Onset of Illness – Enter the time when injury occurred. Must be in a 24-hour time format. For example, enter 21:05 for 9:05 pm, 00:00 for 12 midnight, etc…

Cumulative Injury? – Select from radio button list Yes or No.

Nature of Injury – Select from drop down.

Nature of Accident – Select from drop down.

Date Last Worked – Enter the date when patient last worked. Select from a dropdown calendar.

Date of 1st Exam or Treatment – Enter the date of patient first exam or treatment. Date and hour of patient first exam or treatment must be greater than Date and hour when Injury occurred.

Hour of 1st Exam or Treatment – Enter the time of 1st exam or treatment. Must be in a 24-hour time format. For example, enter 21:05 for 9:05 pm, 00:00 for 12 midnight, etc…

Have you or your office previously rendered treatment? – Select from radio buttons.

Describe how the accident or exposure happened – Enter what the patient describe how the accident or exposure happened. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 50000 characters.

Subjective Complaints – Enter the patient complaints. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 50000 characters.

Objective Findings

Physical Examination – Enter physical examination findings. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 50000 characters.

X-ray and laboratory results – Enter results, specify None or Pending if lab results are not applicable/available.

Diagnoses – Up to 12 Diagnosis details can be provided.

Chemical/Toxic Substance/Pesticide involved? – Select from radio button list.

ICD-10 – Select from a drop down list.

Part of Body - Select from a drop down list.

Diagnosis Description– Enter Diagnosis Description. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 2000 characters.

Is the Injury/Illness Work Related? - Select Yes or No or Unknown

Duration of Exposure-1…12 – Enter in days, hours, and minutes format (DDD.HH.MM).

Are your findings and diagnosis consistent…? – Select Y or N.

Please explain below: - Enter Diagnosis Description. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 50000 characters.

Is there any other current condition that will impede or delay…? – Select Yes or No.

Please explain below: - Enter Diagnosis Description. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 50000 characters.

Treatment Rendered: - Enter Treatment Description. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 50000 characters.

Is further treatment required? – Select Yes or No.

If further treatment required, specify treatment plan. – Enter further treatment description. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 50000 characters.

Estimated Further Treatment Duration – Enter treatment duration in days and hours format (DDD.HH).

Is hospitalized? – Has patient been hospitalized? Please select Yes or No.

Hospital Name – Enter the insurer name. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 60 characters.

Hospital Location Address Look-up - Enter the hospital location. As you type the street number, a drop down list will appear. Select the location you want, it will place the selected data into this field. It will also automatically populate the data into appropriate boxes for Hospital Address Line 1, Hospital City, Hospital State and Hospital Zip.

Date admitted – Enter admitted date. Select from a dropdown calendar.

Estimated length of stay – Enter treatment duration in days (DDDD).

Work Status

Is patient able to perform usual work? - Select Yes or No.

Date when patient can return to:

Regular work – Enter the date when patient can return to work. Select from a dropdown calendar. Either Regular work date or Modified work date has to be filled. If both dates are filled, then Regular work date should be greater than Modified work date.

Modified work – Enter the modified date when patient can return to work. Select from a dropdown calendar. Either Regular work or Modified work date has to be filled. If both dates are filled, then Modified work date should be less than Regular work date.

Work Restrictions -

For each work restriction, fill in the appropriate values. Use the "**Other Restrictions/Limitations**" box for any limitations/suggestions that cannot be measured numerically. You may add up to five work restrictions by selecting the "**Add Work Restriction**" checkbox.

Example (for multiple work restrictions)

No lifting more than 5 lbs. No pushing/pulling > 10 lbs. No repetitive bending/stooping. No standing more than 15 minutes per hour. No climbing/working at heights. Allow breaks as needed.

Fill in the details as shown below:

1.**Restriction**: Lift

Pounds: 5

2.**Restriction**:Push/Pull

Pounds: 10

3.**Restriction**: Bend

Percentage of Working Hours: 0

4.**Restriction**: Stand

Minutes Per Hour: 15

5.**Restriction**: Climb

Part of Body/Object/Restriction Details: Heights

Percentage of Working Hours: 0

Other Restrictions/Limitations: Allow breaks as needed.

Physician signature – Please check the box "I declare…" before enter name in "Signer's Name" box.

Physician First Name: - Auto-populating

Physician Last Name: - Auto-populating

Select from registered addresses – Select from a drop down list.

Physician Phone Number: - Auto-populating

Executed At – Enter location this document was executed at. The field can contain letters, numbers, spaces and special characters, except pipe characters "|" and must not exceed 60 characters.

Date Executed – Enter the date this document was filled and signed. Date Executed must be greater than Injury Date.

Select from registered specialties – Select from a drop down list.

Submit - Click to submit Doctor's First Report form. Please note that the form cannot be edited once submitted.

4.4 Updating the Physician Profile

At the login page, select action **Complete/Edit Account Registration** then click **Next** to open the Physician Profile form.

Select **Modifying an Existing Registration** and click on **Select an account to modify** box to select a physician profile to modify. The physician details will come up and all the appropriate fields will be populated. Make the necessary changes, and click **Submit** when done.

5. Troubleshooting & Support

5.1 Error Messages

The system displays any of the following errors when incorrect data is entered:

- *Please fill all the mandatory fields.*
- *Injury Date should be less than Current Date.*
- *Date of Birth should not be greater than Current Date.*
- *First Exam should not be greater than Current Date.*
- *Injury Date should be greater than Date of Birth.*
- *Date Executed cannot be earlier than Injury Date.*
- *Date Executed cannot be greater than Current Date.*
- *Injury Date and Time should not be greater than first exam Date and Time*.

Users must correct all errors before submitting data.

5.2 Resources and Support

WCIS resources:

Email: dfr_edi@dir.ca.gov