

Doctor's First Report of Occupational Injury Or Illness

Online System User Manual

Version 1.0 02/13/2020

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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.

Cov State of California Department of Industrial Relations
Login Page
STATE OF CALIFORNIA DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS
Important / Please Complete Account Registration before you Submit a Doctor's First Report of Occupational Injury or Illness.
Select an action: * Complete/Edit Account Registration Submit Doctor's First Report of Injury or Illness Form USER MANUAL: DOCTOR'S FIRST REPORT ONLINE SYSTEM USER MANUAL Save Clear Submit

- 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.
- You will need to wait 24 hours after registration to submit a DFR.
- 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.
- Before submitting your completed DFR, click **Validate Form.** 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

Then 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 ^C. 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

Department of Industrial Relation:		
Sign in		
Username		
Password		
Forgot your password?	Register	
Login		

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

	State of California Department of Industrial Relations
Ν	lew user registration
	Email
	First Name
	_ast Name
	Sign Up

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

• Use the **Continue Registration** link in the email to continue

 SimpliGov Registration
Cadir.prod@simpligov.com To: dfrtestuser@yahoo.com
External images are now more secure, and shown by default. Change in Settings
Hello To complete registration you need to follow this link: <u>Continue Registration</u> Didn't request this change?
Ignore this email if you did not submit a request to create an account. This link will expire in one (1) day.
♠ ♠ ➡ …

• Enter your password, then enter again to confirm. All passwords must be at least 8 characters, contain at least three of the four categories: upper case, lower case, a numeral, and a special character. Click **Continue**.

State of California Department of Industrial Relations
Create your password
New Password
Confirm New Password
Continue

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.

State of California Department of Industrial Relations		Dashboard							
New Workflow	Departmen	t of Industrial Relations	Personal Inf	ormation Policy					
Dashboard	Drag a colu	umn header here to group	o by that colu	ımn					
My Tasks	Actions	Workflow Name	Ŧ	Last Updated	Ŧ	Requester	Ŧ	Assignee	
		Q		Q		Q		Q	
FILTERS My Records	000	DFR000000000000000000000000000000000000	0000024	1/29/2020, 10:47 A	М	Test User			
My Action Required	V T [Workflow Description] Equals 'DWC-Doctor's First Report of Injury' And [Log Selection] Equals 'Submit Doctor's First Report of Injury of								
VIEWS	10 20	40							
P DFR Registration View									
Octor's First Report View View View View									

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

C.cov State of California Department of Industrial Relations
Login Page
STATE OF CALIFORNIA DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS
Important / Please Complete Account Registration before you Submit a Doctor's First Report of Occupational Injury or Illness.
Select an action: * Complete/Edit Account Registration Submit Doctor's First Report of Injury or Illness Form USER MANUAL: DOCTOR'S FIRST REPORT ONLINE SYSTEM USER MANUAL
Save Clear Submit

Please wait 24 hours after completing account profile registration to submit Doctor's First Report Form.

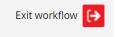
3. Submit Doctor's First Report Form:

• 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.

	Cov State of California Department of Industrial Relations
_L(ogin Page
	STATE OF CALIFORNIA
	DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS
	Important / Please Complete Account Registration before you Submit a Doctor's First Report of Occupational Injury or Illness.
	Select an action: *
	Complete/Edit Account Registration Submit Doctor's First Report of Injury or Illness Form
	USER MANUAL: DOCTOR'S FIRST REPORT ONLINE SYSTEM USER MANUAL
	Save Clear Submit

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.

- Use the Filters to toggle the Dashboard between My Records, My Action Required, and My Tasks.
- Three **Views** are available:
 - **DFR Registration View** filter displays your DFR Registration workflows
 - Doctor's First Report View 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 bove 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**.

State of California California Department of Inductruit Relations		Dashboard					🗘 Test User 🙆
New Workflow		nt of Industrial Relations Person umn header here to group by th					\$5 •
⊘ My Tasks	Actions	Workflow Name	Workflow Description	Status 🔻	Requester T	Created 🔻	Log Selection
		Q	= DWC-Doctor's First Report	Q	Q	۹ 🖬	= Complete/Edit Account Re
FILTERS My Records	000	DFR0000000000000000000	DWC-Doctor's First Report	Completed: Registration	Test User	1/27/2020, 10:29 AM	Complete/Edit Account Regi
My Action Required		DFR0000000000000000000	DWC-Doctor's First Report	Completed: Registration	Test User	1/28/2020, 10:42 AM	Complete/Edit Account Regi
VIEWS	0.0.0	Request # 00642446	DWC-Doctor's First Report	Completed: Registration	Test User	1/27/2020, 10:19 AM	Complete/Edit Account Regi
후 DFR Registration View		DFR0000000000000000000	DWC-Doctor's First Report	Completed: Registration	Test User	1/27/2020, 11:12 AM	Complete/Edit Account Regi
후 Doctor's First Report View	V 🕈 🕅	Workflow Description] Equals 'D\	WC-Doctor's First Report of Injur	y' And [Log Selection] Equals 'Co	mplete/Edit Account Registratio	n'	Clear
♥ User default	10 20	40					Page 1 of 1 (4 items) 1

If you click Save after filling out a DFR, the workflow Status will show as Pending Submission. To continue filling out the pending submission, click the ^{***} icon in the Actions column to open the Actions menu, then select Edit Request. Click Submit after filling out the form to complete the submission. The workflow Status will be changed to Completed Registration.

Workflow Name	Workflow Description	Assignee	Status	Last Updated	Requester
Q	= DWC-Doctor's First Report	Q	Q	۹ 🖬	Q
 DFR000000000000000000000000	DWC-Doctor's First Report	Test User	Pending Submission	1/28/2020, 2:34 PM	Test User
 DFR000000000000000000000000000000000000	DWC-Doctor's First Report		Completed: Registration	1/28/2020, 2:03 PM	Jatel Desai
	DWC-Doctor's First Report WC-Doctor's First Report of Injury	,	Completed: Registration	1/28/2020, 2:03 PM	

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.

Cov Ealifornia Department of Industrial Relations
Login Page
STATE OF CALIFORNIA DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS
Important / Please Complete Account Registration before you Submit a Doctor's First Report of Occupational Injury or Illness.
Select an action: * Complete/Edit Account Registration Submit Doctor's First Report of Injury or Illness Form
USER MANUAL: DOCTOR'S FIRST REPORT ONLINE SYSTEM USER MANUAL
Save Clear Submit

The Registration form will display as below:

		ATE OF CALIFORNIA		
	DOCTOR'S FIR	RST REPORT REGIST	RATION	
				Welcome: Thu V
				ttvu@dir.ca.go
Instructions: Completing the Doctor's First Re	eport Registration Form			
Physician Information				
Enter License Number *			arch License Number details below if No results found	
		Enter datasou		✓ Clear
Physician License State				
CA				
Physician NPI *				
Select/Refresh from the NPPES NPI records				
Selecting this will overwrite previously entered N	PI data.			
		Class		
Enter datasource item	Ŧ	Clear		
Enter datasource item Physician First Name *	Physician Middle N		Physician Last Name *	
	Physician Middle N		Physician Last Name *	
Physician First Name *		ame	Physician Last Name *	
Physician First Name * Physician Address Line 1 *	Physician Middle N Physician Address S	ame	Physician Last Name *	
Physician First Name *		ame	Physician Last Name *	
Physician First Name * Physician Address Line 1 * Street and number, P.O. box		ame	Physician Last Name *	
Physician First Name * Physician Address Line 1 * Street and number, P.O. box	Physician Address S	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City *	Physician Address S Physician State *	ame		
Physician First Name * Physician Address Line 1 *	Physician Address S	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City *	Physician Address S Physician State *	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City *	Physician Address S Physician State *	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City * Physician Organization Name	Physician Address S Physician State *	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City *	Physician Address S Physician State *	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City * Physician Organization Name Physician Specialties	Physician Address S Physician State *	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City * Physician Organization Name Physician Specialties Add at least 1 and up to 5 specialties	Physician Address S Physician State *	ame		
Physician First Name * Physician Address Line 1 * Street and number, P.O. box Physician City * Physician Organization Name Physician Organization Name Physician Specialties Physician Specialty 1 *	Physician Address S Physician State *	ame Suite umber *		

Select one	Ψ		
Physician Specialty 4			
Select one	•		
Physician Specialty 5			
Select one	Ŧ		
	ice Location		
Additional Physician Medical Offi		Clear Back Submit	

Follow these instructions to complete the Registration Page.

- Enter License Number Enter the physician license number. The field can contain letters, numbers, and spaces and must not exceed 30 characters.
- **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 from the 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.

C.	State of California Department of Industrial Relations
Login Pa	Page
	STATE OF CALIFORNIA
	DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS
	Important / Please Complete Account Registration before you Submit a Doctor's First Report of Occupational Injury or Illness.
Selec	ct an action: *
	Complete/Edit Account Registration Submit Doctor's First Report of Injury or Illness Form
USER	R MANUAL: DOCTOR'S FIRST REPORT ONLINE SYSTEM USER MANUAL
	Save Clear Submit

The Doctor's First Report Page screen will display:

	ST	TATE OF CALIFORNIA		
C	OCTOR'S FIRST REPORT	OF OCCUPATIONAL INJURY OR	ILLNESS	
				Welcome: Thu Vu
				ttvu@dir.ca.gov
				DFR Number:
Instructions: Completing the Doctor's First Report				
	Please wait 24 hours	after registration to complete this form.		
Physician Information				
Select license details				
Enter datasource item	~ <u>Cle</u>	ar		
License Number: *	NPI			
License State *				
Doctor's First Report of Injury				
1. Insurer Name *				
Insurer Address Look-up * Address selected will populate the address fields below				
Start typing and select				
Insurer Address (No. and Street) *		Insurer Suite		
Street and number, P.O. box				
Insurer City *	Insurer State *		Insurer Zip *	
2. Employer Name *				
Employer Address Look-up * Address selected will populate the address fields below				
Start typing and select				
3. Address (No. and Street) *		Employer Suite		
Street and number, P.O. box				
City *	State *		Zip Code *	

3. Address (No. and Street) * Street and number, P.O. box		Employer Suite/Apartmen	
City *	State *		Zip Code *
4. Nature of Business * (e.g. food manufacturing, building construction, retaile	r of women's clothes.)		
5. Patient First Name *	Middle Initial		Last Name *
6. Sex * ◉ Female ○ Male ○ Other		7. Date of Birth * MM/dd/yyyy	
Patient Address Look-up Address selected will populate the address fields below Start typing and select			
8. Address * Street and number, P.O. box		Patient Suite/Apartment	
City *	State		Zip Code *
9. Phone Number *	10. Occupation (Specific	Job Title) *	11. Social Security Number
Injury Location Address Look-up Address selected will populate the address fields below			
Start typing and select			
12. Address No. & Street Where Injury Occurred *		Injury Location Suite/Apar	tment
Street and number			
City Where Injury Occurred *	County *		
13. Date of Injury or Onset of Illness *	Hour of Injury or Onset	of Illness *	
06/17/2019			Cumulative Injury? * Ves No
14. Date Last Worked *	15. Date of 1st Exam or	Treatment *	Hour of 1st Exam or Treatment *
06/17/2019	06/17/2019		

8. Subjective Complaints *				
10. Objective Findings				
19. Objective Findings				
A. Physical Examination *				
			le le	
3. X-ray and laboratory results *				
			h,	
20. Diagnoses (if occupational illr	ness specify etiol	ogic agent and duration of exposure.)	li,	
	ness specify etiol	ogic agent and duration of exposure.)	li li	
20. Diagnoses (if occupational illr Occupational illness? * ○ Yes ● No	ness specify etiol		or Toxic Compounds involved? *	
Occupational illness? * Ves No	ness specify etiol	Chemical o		
Occupational illness? * ○ Yes	ness specify etiol	Chemical o Ves		
Occupational illness? * Yes No CD_10 - 1 Enter datasource item	ness specify etiol	Chemical o Ves Etiologic Agent - 1	No	
Occupational illness? * Yes No CD_10 - 1 Enter datasource item Clear	ness specify etiol	Chemical o Ves	No	
Occupational illness? * Yes No CD_10 - 1 Enter datasource item	ness specify etiol	Chemical o Ves Etiologic Agent - 1	No	
Occupational illness? * Yes No CD_10 - 1 Enter datasource item Clear	ness specify etiol	Chemical o Ves Etiologic Agent - 1	No	
Decupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1	ness specify etiol	Chemical o Ves Etiologic Agent - 1	No Duration of Exposure - 1	
Occupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1 CD-10 - 2	•	Chemical o Yes Etiologic Agent - 1 Y N Etiologic Agent - 2	No	
Decupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1	ness specify etiol	Chemical o Yes Etiologic Agent - 1 Y N N	No Duration of Exposure - 1	
Decupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1 CD-10 - 2 Enter datasource item	•	Chemical o Yes Etiologic Agent - 1 Y N Etiologic Agent - 2	No Duration of Exposure - 1	
Occupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1 CD-10 - 2	•	Chemical o Yes Etiologic Agent - 1 Y N Etiologic Agent - 2	No Duration of Exposure - 1	
Occupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1 CD-10 - 2 Enter datasource item Diagnosis Description - 2 Diagnosis Description - 2	•	Chemical o Yes Etiologic Agent - 1 Y N Etiologic Agent - 2	No Duration of Exposure - 1 Duration of Exposure - 2	
Decupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1 CD-10 - 2 Enter datasource item Diagnosis Description - 2 Diagnosis Description - 2 CD_10 - 3	✓ Clear	Chemical o Yes Etiologic Agent - 1 Y N N Etiologic Agent - 2 Y N N	No Duration of Exposure - 1	
Occupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1 CD-10 - 2 Enter datasource item Diagnosis Description - 2 Diagnosis Description - 2	•	Chemical o Yes Etiologic Agent - 1 Y N Etiologic Agent - 2	No Duration of Exposure - 1 Duration of Exposure - 2	
Decupational illness? * Yes No CD_10 - 1 Enter datasource item Clear Diagnosis Description - 1 CD-10 - 2 Enter datasource item Diagnosis Description - 2 Diagnosis Description - 2 CD_10 - 3	✓ Clear	Chemical o Yes Etiologic Agent - 1 Y N Etiologic Agent - 2 Y N N Etiologic Agent - 3	No Duration of Exposure - 1 Duration of Exposure - 2	

Physician First Name: Physician Last Name:				y or onset of	
W Vs No 23. Treatment Rendered * Is further treatment required;* Ys No 25. Is hospitalined ? 26. Work Status Is patient able to perform usual work?* Ys No Date when patient can return to: Regular work* Modified work* 06/17/2019 06/17/2019 Specify 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 153.3.* Physician signature * 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 153.3.* Physician First Name: Physician Last Name: Physician First Name: Physician Last Name: Physician First Name: Decuted At * Physician First Name: Decuted At * Physician First Name: Decuted At * I becuted iter 06/17/2019 Sect from registered addresses Enter datasource item Enter datasource item Clar	22. Is there any other curren	t condition that will im	oede or delay patient's re	covery? *	
<pre>shuther treatment required?*</pre>					
Vision No 25. Is hopelalized?* Vision 26. Work Status 26. Work Status 27. Status 27. Status 28. Work status 29. Status and the loperform usual work?* Yes No No 20. Work status 29. Status and the status and t	23. Treatment Rendered *				
Vision No 25. Is hopelalized?* Vision 26. Work Status 26. Work Status 27. Status 27. Status 28. Work status 29. Status and the loperform usual work?* Yes No No 20. Work status 29. Status and the status and t					
Vision No 25. Is hopelalized?* Vision 26. Work Status 26. Work Status 27. Status 27. Status 28. Work status 29. Status and the loperform usual work?* Yes No No 20. Work status 29. Status and the status and t					1
• Vs • No 26. Work Status 27. Work Status 13. Specify restructions * 06/17/2019 06/17/2019 Specify restructions * 06/17/2019 Optimize and the penality 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 * Physician Signature * Physician Last Name: Physician First Name: Physician Last Name: Optimize Draw Upload Cear Physician Last Name: Optimize Transmitter Content of the tran		? *			
26. Work Status Is patient table to perform usual work?* * Ys * Ys * No Date when patient can return to: Regular work * 0/17/2019 specify restrictions * * * * * * * * * * * * *					
Is patent able to perform usual work?* * YesNO Determined and return to: Regular work *O(17/2019	Ves INO				
• Ys • No Date when patient can return to: Regular work • Modified work • 06/17/2019 06/17/2019 Specify 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 Corr Physician First Name: Physician Phone Number: • Executed At • Date Executed * 06/17/2019 Select from registered addresses • Inter datasource Item Vindet room	26. Work Status				
Regular work* 06/17/2019 Specify 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 193.3.* Physician signature * Signer's Name Jyge Draw Upload Clear Physician First Name: Date Executed * 06/17/2019 Select from registered addresses Inter datasource item vidiate rom		ual work? *			
Regular work* 06/17/2019 Specify 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 193.3.* Physician signature * Signer's Name Jyge Prow Upload Clear Physician First Name: Date Executed * 06/17/2019 Select from registered addresses Inter datasource item • Vidiate rom	Date when patient can retur.	n to:			
06/17/2019 Specify 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 1 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 1 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 1 adeclare 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 1 adeclare 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 Physician signature * Physician Signer's Name Jyge Draw Uplood Clear Physician Phone Number: Executed At * Date Executed * 06/17/2019 06/17/2019 Select from registered addresses Enter datasource item videat form				Modified work *	
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 Tasa.* Physician signature * Signer's Name Iyge Drew Upload Clear Physician First Name: Physician First Name: Physician First Name: Physician Phone Number: Executed At * Date Executed * Dot (7/2019) Select from registered addresses Enter datasource item Clear					
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 Tasa.* Physician signature * Signer's Name Iyge Drew Upload Clear Physician First Name: Physician First Name: Physician First Name: Physician Phone Number: Executed At * Date Executed * Dot (7/2019) Select from registered addresses Enter datasource item Clear					
Physician First Name: Physician Last Name: Physician Last Name: Physician Phone Number: Executed At * Date Executed * D6/17/2019 Select from registered addresses Enter datasource item Clear Ualidate Form	139.3. *	perjury that this repo	rt is true and correct to th	ne best of my knowledge an	d that I have not violated Labor Code section
Physician Phone Number: Executed At * Date Executed * 06/17/2019 Select from registered addresses Enter datasource item Clear Ualidate Form		e Draw Upload Cle	ar		
Select from registered addresses Enter datasource item Clear Validate Form					
Enter datasource item	-			Physician Last Name:	
Validate Form	Physician First Name:		Executed At *	Physician Last Name:	
	Physician First Name: Physician Phone Number:	:SeS	Executed At *	Physician Last Name:	
	Physician First Name: Physician Phone Number: Select from registered addre	sses	Executed At *		

Follow these instructions to complete 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

Doctor's First Report of Injury

- Insurer Name Enter the insurer name. The field can contain letters, numbers, spaces and special characters, except the pipe character "|" and must not exceed 60 characters. Insurer Address Look-up – Enter the insurer address. As you type the street number, a drop-down list will appear. Select the appropriate address. This will automatically populate the data into this field as well as into those for Insurer Address, Insurer City, Insurer State, and Insurer Zip.
- 2. **Employer Name -** Enter the employer 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 appropriate address. This will automatically populate the data into this field as well as into those for Employer Address, City, State, and Zip code.

- 3. **Address –** Auto-populating.
- 4. Nature of Business Enter the industry to which the employer belongs (e.g. food manufacturing, building construction, retailer of women's clothes, etc.). The field can contain letters, numbers, spaces and special characters, except the pipe characters "|" and must not exceed 60 characters.
- Patient First Name Enter the patient's 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's last name. The field must not exceed 60 characters.

- 6. **Sex** Select from radio buttons.
- 7. Date of Birth Enter the patient's Date of Birth. Select from the drop-down calendar. Patient Address Look-up - Enter the patient's address. As you type the street number, a drop-down list will appear. Select the appropriate address. This will automatically populate the data into this field as well as into those for Patient Address, City, State, and Zip Code.
- 8. **Address** Auto-populating
- 9. **Phone Number** Enter the patient's ten-digit phone number.

- 10. **Occupation** Enter the patient's job title. The field must not exceed 60 characters.
- 11. **Social Security Number** Enter the patient's SSN with dashes. For example, enter 123-45-6789.

Injury Location Address Look-up – Enter the location where the injury occurred. As you type the street number, a drop-down list will appear. Select the appropriate address. This will automatically populate the data into this field as well as into those f for Address, City, and County where Injury occurred.

- 12. Address No. & Street Where Inj. Occurred Auto-populating.
- 13. **Date of Injury or Onset of Illness** Enter the date when the injury occurred. Select from the drop-down calendar. Date of Injury must be greater than the Date of Birth and less than Current Date.

Hour of Injury or Onset of Illness – Enter the time when the injury occurred. Must be in a 24-hour time format. For example, enter 21:05 for 9:05 pm, 00:00 for midnight, etc... **Cumulative Injury**? – Select from the radio button list Yes or No.

- 14. **Date Last Worked** Enter the date when the patient last worked. Select from the dropdown calendar.
- 15. Date of 1st Exam or Treatment Enter the date of the patient's first exam or treatment. Date and hour of patient's 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 midnight, etc...

- 16. **Have you or your office previously rendered treatment?** Select from the radio buttons.
- 17. **Describe how the accident or exposure happened –** Enter the patient's description of how the accident or exposure happened. The field can contain letters, numbers, spaces and special characters, except the pipe character "|" and must not exceed 50000 characters.
- 18. **Subjective Complaints –** Enter the patient's complaints. The field can contain letters, numbers, spaces and special characters, except the pipe character "|" and must not exceed 50000 characters.

19. Objective Findings

- A. Physical Examination Enter physical examination findings. The field can contain letters, numbers, spaces and special characters, except the pipe character "|" and must not exceed 50000 characters.
- B. **X-ray and laboratory results** Enter results, specify *None* or *Pending* if lab results are not applicable/available.
- 20. **Diagnoses** Up to 12 Diagnosis details can be provided. **Occupational illness?** Select from the radio button list.

Chemical or Toxic Compounds involved? – Select from the radio button list. ICD-10 – Select from the drop-down list. Etiologic Agent-1...12 – Select from the radio button list Y or N. Duration of Exposure-1...12 – Enter in days, hours, and minutes format (DDD.HH.MM).

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

- 21. 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 the pipe character "|" and must not exceed 50000 characters.
- 22. 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.

- 24. **If further treatment required, specify treatment plan**. Enter further treatment description. The field can contain letters, numbers, spaces and special characters, except the pipe character "|" and must not exceed 50000 characters.
- 25. Is hospitalized? Has patient been hospitalized? Please select Yes or No. Hospital Name – Enter the hospital name. The field can contain letters, numbers, spaces and special characters, except the pipe character "|" 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 appropriate address. This will automatically populate the data into this field as well as into those for Hospital Address Line 1, Hospital City, Hospital State, and Hospital Zip.

Date admitted – Enter admitted date. Select from the drop-down calendar. **Estimated length of stay** – Enter treatment duration in days format (DDDD), must not exceed four characters.

26. 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 the patient can return to work. Select from the drop-down calendar.

Modified work – Enter the modified date when the patient can return to work. Select from the drop-down calendar.

Specify restrictions – Enter the description of any restrictions. Must not exceed 2000 characters.

Physician signature – Check the box "I declare..." and enter the name in "Signer's Name" box.

Physician First Name: - Auto-populating

Physician Last Name: - Auto-populating

Select from registered addresses – Select from the drop-down list.

Physician Phone Number: - Auto-populating

Executed At – Enter location where this document was executed. The field may contain letters, numbers, spaces and special characters, except the pipe character "|" 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 the drop-down list.

Form Status: - Click on the "**Validate Form**" button to verify form submission. If there are any errors, the error messages will be displayed in this box. The errors must be corrected before submission.

4.4 Updating the Physician Profile

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

	Cook State of California Department of Industrial Relations
_Lc	ogin Page
	STATE OF CALIFORNIA
	DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS
	Important / Please Complete Account Registration before you Submit a Doctor's First Report of Occupational Injury or Illness.
	Select an action: *
	Complete/Edit Account Registration Submit Doctor's First Report of Injury or Illness Form
	USER MANUAL: DOCTOR'S FIRST REPORT ONLINE SYSTEM USER MANUAL
	Save Clear Submit

Enter your previously registered license number in the **Enter License Number** box and click on **Click here to search License Number** box as follows:

STAT	E OF CALIFORNIA	
DOCTOR'S FIRS	T REPORT REGISTRATION	
		Welcome: Thu Vu
		ttvu@dir.ca.gov
		ttrac annealgor
Instructions: Completing the Doctor's First Report Registration Form		
Physician Information		
		•
Enter License Number *	Click here to search License Number Enter Physician details below if No results found	
	Enter datasource item	Clear
Physician License State		
CA		
Physician NPI *		

The physician details will come up and all the appropriate fields will be populated. Make the necessary changes, and click **Submit** when done.

		F CALIFORNIA REPORT REGISTRATION		
				Welcome: Test Vu
				ttvu3@yahoo.com
Instructions: Completing the Doctor's First Report Regi	stration Form			
Physician Information				
		Click here to search License Nur	nber	
Enter License Number *		Enter Physician details below if No	results found	
TEST456		TEST456 1245602770 BROOKE	OWEN -	<u>Clear</u>
Physician License State *				
CA ~				
Physician NPI *				
1245602770				
Physician First Name *	Physician Middle Name		Physician Last Name *	
BROOKE			OWEN	
Physician Address Line 1 *	Physician Address Suite			
5959 CENTRAL AVE				

Physician City *	Physician State *	Physician Zip *
ST PETERSBURG	FL	337108502
Physician Organization Name	Physician Email	Physician Phone Number *
		(925) 467-8900
Physician Specialties		
Add at least 1 and up to 5 specialties		
Physician Specialty 1 *		
Acupuncturist	•	
Physician Specialty 2		
Allergy & Immunology		
Physician Specialty 3		
Dermatology	•	
Physician Specialty 4		
Acupuncturist	•	
Physician Specialty 5		
Psychiatry & Neurology : Psychiatry	•	
Additional Physician Medical Office Location		
Additional Physician Medical Office Location		
Additional Physician Medical Office Location		
	Save Clear Back Submit	

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