SECOND INJURY FUND EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE

This form is to be used only after an applicant has been made a conditional job offer

Confidential Health Information

Dear Employee,

The Louisiana Second Injury Fund helps us to hire and keep our qualified employees. To apply for Second Injury Fund's protection, we must show that we knew about your prior accidents, injuries and medical condition(s). If you are injured at work the second injury board may pay some of our costs related to a new work injury. You still get paid 100% of your benefits. We both win!

Your answers in this questionnaire will help us to prove our "prior" knowledge. Your answers are CONFIDENTIAL. The information is used only for workers' compensation purposes; to assist us in determining your ability to perform the essential functions of your job, and to determine what job modification, if any, you may need.

Our goal is to make our workplace a safer place, for you and all of our employees, to work

Your Management Team

NOTE: Failure to answer truthfully and/or correctly to any of the questions on this form may result in a forfeiture of your right to receive workers compensation benefits under La. R.S. 23.1208.1.

Please acknowledge the following:

- I have been offered employment as a ___________________________________ **Initials [_____]**
- I am physically able to do the job offered to me. **Initials [_____]**
- I understand that for safety reasons, this is a drug free work place. **Initials [_____]**
- I understand that I may be required to take a random drug test. **Initials [_____]**
- I understand that the position offered to me is classified as **part-time employment** and that I will customarily work less than forty hours (40) a week. Initial Yes **[__________] No [__________]**
- I understand that the position offered to me is classified as **full-time position**. Initial Yes **[_______] NO [______]**

Last four digits of my social security number is _____ _____ _____ ______

Your Name ____

Your Signature ____ **Date** _________________

Employers' Signature ____ **Date** _______________

© 2000, 2001, 2002, 2009, 2011, 2012, 2013.1, 2014, 2015, 2017, 2019

SECOND INJURY FUND EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE

This form is to be used only after an applicant has been made a conditional job offer

Print Your Name ____ **Phone No.:** ________________
Address ____ **City:** ______________ **St.:** _____

Last Employer ___________________________ **City/St:** _______________ **Phone No.:** ________________

Family doctor/clinic ____ **City:** ______________ **St.:** _____
Last Visit Year: _________ **Condition:** ______________________ **Phone No:** ________________

I am _____ feet and ______ inches tall. I weigh about ________ pounds. **Gender _______ Date of Birth _____________**

Have you ever had a broken (fractured) bone(s)? Yes [__] No [__] If Yes, list all fractured bone(s)

____

Indicate if you have seen a doctor or been treated for any of the following:

Back pain or Injury?	Yes [ ] No [ ] If yes, when _______	**Head injury?**	Yes [ ] No [ ] If yes, when _______
Knee pain or injury?	Yes [ ] No [ ] If yes, when _______	**Migraine Headaches?**	Yes [ ] No [ ] If yes, when _______
Neck pain or injury?	Yes [ ] No [ ] If yes, when _______	**Shoulder pain or Injury?**	Yes [ ] No [ ] If yes, when _______
Ruptured Disc?	Yes [ ] No [ ] If yes, when _______	**Elbow or arm injury?**	Yes [ ] No [ ] If yes, when _______
Serious Burns?	Yes [ ] No [ ] If yes, when _______	**Hand or wrist injury?**	Yes [ ] No [ ] If yes, when _______
Hernia?	Yes [ ] No [ ] If yes, when _______	**Leg, ankle or foot injury?**	Yes [ ] No [ ] If yes, when _______

Have you ever had surgery? Yes [ ] No [ ] If Yes, please list ALL of your surgeries:

____

Indicate either "Yes" or "No" if you have or had any of the following conditions:

YES [___] NO [___]. **Heart /Coronary** Disease including arteriosclerosis, Rheumatic fever, Thrombophlebitis Stroke, Varicose Vines

YES [___] NO [___]. **Lung Disease** including COPD, Asthma, Asbestosis, Bronchitis, Emphysema, Tuberculosis, or Silicosis

YES [___] NO [___]. **Neurological or Muscle Disorder** including Cerebral Palsy, Parkinson, Multiple Sclerosis, Muscular Dystrophy, or Poliomyelitis

Allergies *YES [__] NO [__].* **Arthritis** *YES [__] NO [__].* **Cancer** *YES [__] NO [__].* **Diabetes** *YES [__] NO [__].* **High or Low Blood Pressure** *YES [__] NO [__].*
Hepatitis *YES [__] NO [__].* **A Blood Disorder** *YES [__] NO [__].* **Fibromyalgia** *YES [__] NO [__].* **Kidney Disorder** *YES [__] NO [__].* **Liver Disease** *YES [__] NO [__].*
Loss of Sight *YES [__] NO [__].* **Loss of hearing** *YES [__] NO [__].* **Learning disability** *YES [__] NO [__].* **Reflex Sympatric Dystrophy** *YES [__] NO [__].*
Eye Disease *YES [__] NO [__].* **Psychiatric Treatment** *YES [__] NO [__].***Seizures** *YES [__] NO [__].* **Skin Disorder** *YES [__] NO [__].* **Stomach Disorder** *YES [__] NO [__].*
Any Sports Injury *YES [__] NO [__].* **Any Work Injury** *YES [__] NO [__].* **Injury from auto accident** *YES [__] NO [__].* **Knife or Gun Shot injury** *YES [__] NO [__].*

Do you have any *Other Medical Conditions*? *YES [___] NO [____].* **If yes, please list ALL other conditions:**

____

Have you been treated for Drug or Alcohol Addiction? Yes *[___] NO [___].* Do you have or have you had, any Work Restriction? Yes *[___] NO [___].*
Have you applied for SSDI? Yes *[___] NO [___].* If Yes, Date Applied ___________**Were you approved for SSDI? Yes *[___] NO [___].* Date approved** ___________
Have you taken any medication during the last 12 months? Yes *[___] NO [___].* If yes, List ALL medications you have taken:

____

WARNING: Pursuant to LSA-R.S. 23:1208.1, I understand that my failure to answer truthfully any of the above questions may result in denial or forfeiture of any right I, or my dependents, may have to workers' compensation benefits, including medical treatment and expenses. [12-point font]

I acknowledge that I have read or had the questionnaire read to me and I understand the 23:1208.1 warning

Your Signature ____ **Date** ______________

© 2000, 2001, 2002, 2009, 2011, 2012, 2013.1, 2014, 2015, 2017, 2019

SECOND INJURY FUND EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE

This form is to be used only after an applicant has been made a conditional job offer

If you answered "Yes" to any of the questions on the previous page, please use this space to explain your answers.

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Your Signature ____ **Date** ______________

Employer Signature ____ **Date** ______________

© 2000, 2001, 2002, 2009, 2011, 2012, 2013.1, 2014, 2015, 2017, 2019

SECOND INJURY FUND EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE

This form is to be used only after an applicant has been made a conditional job offer

Employer Certification of Prior Knowledge

The information provided by this employee is confidential and should only be used for workers' compensation purposes. Other uses of this information may be prohibited by law and should be discussed with *corporate counsel*.

All new employee should complete a Second Injury Fund Employee Questionnaire.

Consider having all employees update their information annually.

All completed questionnaires should be kept in a secure and confidential file. Access to the information should be on a need-to-know basis and limited to job safety, job modification, workers compensation and second injury fund purposes.

Consult with a professional labor adviser for proper handling and storage of this questionnaire.

Review the employee's answers; were all questions answered?
NO BLANKS. THE EMPLOYEE SHOULD ANSWER ALL QUESTIONS.

HAVE EMPLOYEE EXPLAIN ALL AFFIRMATIVE ANSWERS

Employee can write their explanation on the **blank questionnaire page** or a blank sheet of paper. If additional pages are required the employee and the person with functional responsibility to hire and/or terminate employment should sign and date each additional page. Do you understand this employee's answers and explanations? Ask questions and keep your own notes. Sign and date your notes and attach your notes to the questionnaire. Keep all documents, questionnaire, explanations pages and your notes together.

Is the employee able to perform the essential functions of the job offered without danger to themselves or to their fellow employees? Questions about this employee's ability to perform the essential functions of their job or other work place safety concerns should be discussed with your company's occupational medicine physician. *Always consult with a professional labor adviser to determine what additional actions, if any, you should take.*

I have reviewed the Second Injury Fund Employee Questionnaire completed by [SS ID #] ____ ____ ____ ____ and I certify that I have both the authority and a functional responsibility for hiring and/or employment termination decisions.

Employer Signature ____ Date ____________

Print Name ____

11.7

© 2000, 2001, 2002, 2009, 2011, 2012, 2013.1, 2014, 2015, 2017, 2019