SUPPLEMENTAL PAGE

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: _____ **Date of Birth:** _____

This is a supplemental page. If you answered "YES" to any of the previous questions from Page 2-3, please use this space to continue your answers from Page 3 of the Second Injury Fund Employee Medical History Questionnaire.

Your Signature _____ **Date** _____

Employer Signature _____ **Date** _____

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

© 2000, 2001, 2002, 2009, 2011, 2012, 2013.1, 2014, 2015, 2017, 2019, 2022