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,

Our goal is to provide a safer workplace for all of our employees.

The Louisiana Second Injury Fund is a state program designed to encourage us to hire and keep qualified employees who may have prior injuries or illnesses. To apply for Second Injury Fund's protection, we must show that we knew about prior accidents, injuries, and medical condition(s). If you have a new injury, you are still paid 100% of your benefits. If the Second Injury Board accepts our application, the Second Injury Fund will pay some of our costs related to your new work injury.

Your answers on this questionnaire will help us 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 any job modification you may need.

Safety & Risk Management

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 answer and acknowledge the following:

Your Name: _____ Date of Birth: _____

I am _____ feet and _____ inches tall. I weigh _____ pounds. Gender: _____

- 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 **full-time position**. **Initial** Yes **[_____] NO [_____]**
- 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 [_____]**

My social security number is ____ ____ ____ - ____ ____ - ____ ____ ____ ____

Your Signature _____ Date _____

Employers' Signature _____ Date _____

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Print Your Name: _____**Phone No:** _____

Address: _____**City:** _____**St.:** _____ **Zip:**_____

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

Back 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 _____	**Knee pain or injury?**	Yes [ ] No [ ] If yes, when _____
Head injury?	Yes [ ] No [ ] If yes, when _____	**Leg, ankle or foot injury?**	Yes [ ] No [ ] If yes, when _____

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

_____

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 Veins

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

YES [___] NO [___]. **Allergies** including Drug, Latex, Pollen, Pet, Mold, Insects, Food, or Gluten

Arthritis *YES [ ] NO [ ]*	**Blood Disorder** *YES [ ] NO [ ]*	**Learning Disability** *YES [ ] NO [ ]*
Cancer *YES [ ] NO [ ]*	**Kidney Disorder** *YES [ ] NO [ ]*	**Psychiatric Treatment** *YES [ ] NO [ ]*
Diabetes *YES [ ] NO [ ]*	**Fibromyalgia** *YES [ ] NO [ ]*	**Reflex Sympathetic Dystrophy** *YES [ ] NO [ ]*
High/Low Blood Pressure *YES [ ] NO [ ]*	**Eye Disease** *YES [ ] NO [ ]*	**Post-Traumatic Stress Disorder** *YES [ ] NO [ ]*
Hepatitis *YES [ ] NO [ ]*	**Loss of Vision/Sight** *YES [ ] NO [ ]*	**Any Sports Injury** *YES [ ] NO [ ]*
Liver Disease *YES [ ] NO [ ]*	**Loss of Hearing** *YES [ ] NO [ ]*	**Any Work Injury** *YES [ ] NO [ ]*
Stomach Disorder *YES [ ] NO [ ]*	**Periodontal Disease** *YES [ ] NO [ ]*	**Injury from Auto Accident** *YES [ ] NO [ ]*
Skin Disorder *YES [ ] NO [ ]*	**Seizures** *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:** _____

_____

WARNING: PURSUANT TO LA. 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** _____

Employers' Signature _____ **Date** _____

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Print Your Name: _____ **Age:** _____

Last Employer:_____ **City/St:** _____ **Phone No.:**_____

Family doctor/clinic: _____ **City:** _____**St.:** _____

Last Visit Year: _____ **Condition:** _____ **Phone No:** _____

Indicate either "Yes" or "No"

Have you been treated for Alcohol Addiction Yes *[___] NO [___].*

Have you been treated for Drug Addiction Yes *[___] NO [___].*

Do you have, or have you had, any Work Restriction(s)? Yes *[___] NO [___].*

Have you applied for Social Security's Disability Insurance? Yes *[___] NO [___].* If Yes, Date Applied _____

Were you approved for Social Security's Disability Insurance? Yes *[___] NO [___].* Date approved _____

Have you taken any medication during the last 12 months? Yes *[___] NO [___].*

If yes, List ALL medications you have taken: _____

_____

If you answered "YES" to any of the questions, please use this space to explain your answers. If additional writing space is needed ask for an additional, supplemental answer page(s).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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.

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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 [YES] 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 _____