SECOND INJURY FUND EMPLOYEE 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 protects jobs. It encourages all employers to hire and keep qualified workers who have been previously injured, have a pre-existing medical condition or work restriction(s).

To apply for Second Injury Fund protection, we must show that we had knowledge of your injuries, medical conditions, and accidents. If you are injured at work we will use your answers in this questionnaire to establish our prior knowledge when we make a Second Injury Fund claim.

Your answers will be confidential and will only be used for workers' compensation purposes to help determine your ability to perform the essential functions of your job and to make reasonable job accommodations, when appropriate. Our goal is to make our workplace safer for you and all employees.

Your Management Team

Instructions to Employee

- **Ask for help if you do not understand a question.**
- **You must answer all questions, truthfully!**
- **Use a blank sheet of paper to explain all "yes" answers**
- **Sign and date all pages**

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 HAVE [____] HAVE NOT [____]** been guaranteed full time employment of 40 hours a week.
- My social security number is _____ _____ _____-_____ _____-_____ _____ _____ _____

Your Signature _____ **Date** _____

Employers' Name _____

Employers' Signature _____ **Date** _____

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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, please 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 [__].* **High or Low Blood Pressure** *YES [__] NO [__].* **Hepatitis** *YES [__] NO [__].*
A Blood Disorder *YES [__] NO [__].* **Epilepsy** *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 [__].* **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.

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

Your Signature _____ **Date** _____

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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** _____

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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*.

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 questionnaire 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. Have the employee sign and date all explanation pages. Do you understand their 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 preform 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 functional responsibility for hiring and/or employment termination decisions.

Employer Signature _____ **Date** _____

Print Name _____