Name: _____ **Date:** _____

Agency/Department: _____ **Position:** _____

LOUISIANA SECOND INJURY FUND
POST OFFER, PRE-EXISTING CONDITIONS, INJURIES OR ILLNESSES
MEDICAL INQUIRY (E-2)

NOTICE TO EMPLOYEES:
Your employer is committed to providing Workers' Compensation benefits, in accordance with state law, if you sustain an employment-related injury. This form requests medical information and will be kept confidential and separate from your personnel file. It will be used only in the event you experience a work-related injury and become eligible for Workers' Compensation benefits. The employer requires that all employees complete this questionnaire upon hire and every two years thereafter. The information is needed because if a work-related injury or disability is caused or made worse by a pre-existing condition, your employer may be able to seek reimbursement of the benefits paid from the Louisiana Second Injury Fund. This reimbursement would not reduce your workers' compensation benefits. In order to be considered for reimbursement, an employer must show it knowingly hired or knowingly retained an employee with a pre-existing disability. Disclosure of a pre-existing condition shall not be used for any discriminatory purpose. **THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION BENEFITS UNDER LA. R.S. 23:1208.1.**

SECTION 1: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Do not leave any blank unanswered. Please provide explanations for all "yes" responses under Remarks.

YES	NO		YES	NO	
☐	☐	Amputation (foot, leg, arm, hand, or total loss thereof)	☐	☐	Loss of Use of Limbs
☐	☐	Ankylosis of Joints	☐	☐	Mental Disorders
☐	☐	Arteriosclerosis	☐	☐	Mental Retardation
☐	☐	Arthritis	☐	☐	Multiple Sclerosis
☐	☐	Asbestosis	☐	☐	Muscle, Ligament or Tendon Injury
☐	☐	Asthma	☐	☐	Muscular Dystrophy
☐	☐	Back/Neck Problem	☐	☐	Nervous Disorders
☐	☐	Brain Damage	☐	☐	Numbness of Extremities
☐	☐	Bronchitis	☐	☐	Parkinson's Disease
☐	☐	Cancer	☐	☐	Psychoneurotic Disability (following treatment in a recognized medical or mental institution)
☐	☐	Cardiac Disease			
☐	☐	Carpal Tunnel Syndrome			
☐	☐	Cerebral Vascular Accident	☐	☐	Reflex Sympathetic Dystrophy
☐	☐	Chronic Headaches	☐	☐	Repetitive Motion Injury
☐	☐	Chronic Osteomyelitis	☐	☐	Residual Disability from Polio
☐	☐	Compressed Air Sequelae	☐	☐	Rheumatism
☐	☐	Diabetes	☐	☐	Rotator Cuff Injury
☐	☐	Dizziness	☐	☐	Ruptured Intervertebral Disc
☐	☐	Double Vision (blurred sight)	☐	☐	Silicosis
☐	☐	Emphysema	☐	☐	Spinal Fusion
☐	☐	Epilepsy	☐	☐	Stroke
☐	☐	Head Injury	☐	☐	Sugar in Urine
☐	☐	Heart Condition	☐	☐	Surgical Removal of Intervertebral Disc
☐	☐	Heavy Metal Poisoning	☐	☐	Thrombophlebitis
☐	☐	Hemophilia	☐	☐	Thoracic Outlet Syndrome
☐	☐	High/Low Blood Pressure	☐	☐	Thyroid Condition

☐	☐	Hodgkin's Disease	☐	☐	"Trick" Knee or Shoulder
☐	☐	Hyperinsulinism	☐	☐	Tuberculosis
☐	☐	Hypertension	☐	☐	Varicose Veins
☐	☐	Ionizing Radiation Injury			
☐	☐	Kidney Disorder			
☐	☐	Loss of Hearing (more than 75%)			
☐	☐	Loss of Sight (of one or both eyes or a partial loss of uncorrected vision)			

REMARKS: If you answered "yes" to any question above, indicate the nature of the injury/illness, name and address of the treating health care provider, area of specialty and approximate date/year of the illness/injury.

_____

_____

_____

_____

SECTION 2: PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE AS MUCH INFORMATION AS POSSIBLE.

1. Has any doctor ever restricted your activities due to injury, disability or medical condition?

☐ Yes ☐ No

If yes, please describe the reason for the restrictions, the type of restrictions, whether the restrictions were temporary or permanent, and whether you presently have any restrictions on your physical activities.

_____

_____

2. Have you ever been assessed any percentage of permanent disability to any part of your body?

☐ Yes ☐ No If yes, please explain:

_____

_____

3. Are you presently or have you ever been under the care of a doctor, chiropractor, or other health care provider for any serious injury, disability or medical condition?

☐ Yes ☐ No

If yes, please list the condition, injury or illness(s) being treated, the name of the doctor(s), field of specialty, address and telephone number, and dates of treatment.

_____

_____

4. Are you presently or have you ever taken any medication for any serious injury, disability or medical condition?

☐ Yes ☐ No

If yes, please list the name or type of medication, the medical condition being treated, and the name, address and telephone number of the physician who prescribed the medication, area of specialty, and dates of treatment.

_____

_____

5. Have you ever had surgery (other than cosmetic) to any part of your body ? ☐ Yes ☐ No

If yes, please list the part(s) of the body operated on, the type of operation performed, the date (or approximate date), the hospital, and the name, address, and phone number of the doctor performing the surgery (if known).

_____

_____

_____

6. Have you ever received treatment for your head, neck, back or extremities (arms, wrists, legs, knees, etc.) from a doctor, chiropractor, physical therapist or other health care provider?

☐ Yes ☐ No

If yes, please list the name, address and phone number of all doctors, chiropractors, physical therapists, and other health care providers who provided such treatment, the dates of the treatment and the diagnosis provided.

_____

_____

_____

7. Are you aware of any physical condition or injury that might impair or limit your ability to work in this position? ☐ Yes ☐ No If yes, please describe the condition or injury.

_____

_____

8. Have you ever received workers' compensation benefits for an injury that occurred at work?

☐ Yes ☐ No

If yes, please list the name of the employer, the nature of the injury and the dates, and the dates you received compensation.

_____

_____

I HAVE READ ALL ____ PAGES OF THE LOUISIANA SECOND INJURY FUND POST OFFER OF EMPLOYMENT MEDICAL INQUIRY. I FULLY UNDERSTAND AND HAVE TRUTHFULLY AND FULLY ANSWERED ALL OF THE QUESTIONS, TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

I UNDERSTAND THAT MY FAILURE TO TRUTHFULLY ANSWER ANY OF THE ABOVE QUESTIONS MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION STATUTE (LA.R.S. 23:1208.1).

SIGNATURE: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____

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