SECOND INJURY FUND EMPLOYEE QUESTIONNAIRE

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

Print Your Name _____

My Physical Address is_____

My Phone Numbers are_____

Last Employer's Name _ _____

Last Employer's Address _____

Last Employer's Phone Number _____

Name of family doctor or clinic _____**Year** _____

Have you ever had any **Broken Bones? Yes [___] No [___] If Yes, list all bone fractures(s)?**

_____

Have you ever seen a medical doctor or been treated for any of the following:

Back Injury? Yes [ ] Yr _____No [ ] Neck injury? Yes [ ] Yr _____ NO [ ]

Shoulder injury? Yes [ ] Yr _____No [ ] Elbow injury? Yes [ ] Yr _____ NO [ ]

Ankle injury? Yes [ ] Yr _____ No [ ] Knee injury? Yes [ ] Yr _____ NO [ ]

Head injury? Yes [ ] Yr ____ NO [ ] Eye Injury? Yes [ ] Yr _____ NO [ ]

List all surgeries you have had:

_____

Indicated either "Yes" or "No" if you have or could have any of the following conditions:

Arthritis [_____], Cancer [____], Diabetes [____], Epilepsy [____], Heart Disease [_____],

High Blood Pressure [____], Hepatitis [____], Muscle Disease(s) [____], Neurological Disease [___],

Loss of hearing [____], Loss of Sight [_____], Lung Disease [____], Kidney disease [____]

A Blood Disease or Disorder [____], Liver Disease [_____], Psychiatric treatment [____]

A learning disability [____], Drug or Alcohol Addiction [____], your weight _____ Height _____

Have you taken any prescription medications in the last years? [____] If "Yes" list **ALL** medications.

_____

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. ***(11 point Kerning)***

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

Your Signature _____**Date** _____

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Confidential Health Information

Dear Employee,

The Second Injury Fund is a law that encourages all employers to hire and retain qualified people, even if they have had a prior injury or a pre-existing medical condition. In order for us to apply for Second Injury Fund reimbursement we must show that we had knowledge of your prior accidents, injuries and medical condition(s). Your answers in this questionnaire will be used to establish our prior knowledge.

We will keep this information Confidential. We will use this information for workers' compensation purposes, to assist us in determining your ability to perform the essential functions of your job and to determine what reasonable accommodations, if any, we may need to make in your job duties.

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

Safety & Risk Management

Instructions to Employee

- **Do not complete this questionnaire if you have not been offered a job!**
- **Ask for help if you do not understand a question.**
- **You must answer all questions, truthfully!**

I certify that:

- I have been offered employment. **Initials [_____]**
- I am physically able to do the job offered to me. **Initials [_____]**
- I understand that for safety reasons that 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 a **40 hours** work week.
- My social security number is _____ _____ _____-_____ _____-_____ _____ _____ _____

Your Signature _____ Date _____

Employers' Name _____

Employers' Signature _____ Date _____