

# Second Injury Fund Employee Questionnaire



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

Dear Employee,

The **Second Injury Fund** 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.

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

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 \_\_\_\_\_

# 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?

## 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 [ ]

Please explain all "YES" answers and list any surgeries you have had: \_\_\_\_\_

## INDICATE EITHER "YES" OR "NO" IF YOU HAVE OR IF YOU HAVE EVER HAD 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 2 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 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 have had the questionnaire read to me and understand the warning.***

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONFIDENTIAL HEALTH INFORMATION**