

CONFIDENTIAL Second Injury Fund Questionnaire

(Duplication of form is permissible. To be completed post-offer, pre-hire.)

This medical information is being gathered in compliance with the Americans with Disabilities Act (ADA) and will be maintained in a separate medical file as a confidential medical record, except that supervisors/managers may be informed about necessary work restrictions and accommodations, first-aid/safety personnel may be informed of any necessary information for emergency medical treatment, and the government may be provided with this information when enforcing the ADA. 42 U.S.C.A. § 12112(d) (West 2007). In addition, the employer reserves the right to use this information to assist in presenting a claim for reimbursement under any Subsequent/Second Injury Trust Fund. 29 C.F.R. app. § 1630.14(b) (West 2007); and LA. REV. STAT. ANN. § 23:1208.1 (West 2007).

Name of employer _____

Name of employee _____ Phone number _____

Employee's Social Security number _____ Height _____ Weight _____

1. Do you now have, or have you ever had, any of the following?

Yes	No		Yes	No		Yes	No	
		Amputation of foot, leg, arm or hand			Diabetes (medication <input type="checkbox"/> Yes <input type="checkbox"/> No)			Multiple sclerosis
		Ankylosis of a joint (frozen joint)			Epilepsy (convulsions, seizures)			Muscular dystrophy
		Arteriosclerosis			Fractures			Parkinson's disease
		Arthritis			Gastroesophageal reflux disease			Polio (poliomyelitis)
		Brain damage			Heavy-metal poisoning			Psychiatric/Psychological treatment or nervous condition
		Cancer (any type)			Hemophilia			Silicosis
		Cardiac or heart problems			Herniated disk (back or neck injury)			Stroke
		Carpal tunnel syndrome			High blood pressure			Surgical removal of a disk, or spinal fusion
		Cerebral palsy			Hodgkin's Disease			Thrombophlebitis
		Cerebral vascular accident			Hyperinsulinism			TMJ (temporomandibular joint disorder)
		Chronic fatigue syndrome			Ionizing radiation injury			Tuberculosis
		Chronic osteomyelitis (infection in bone)			Knee surgery			Ulcers
		Complex regional pain syndrome or reflex sympathetic dystrophy			Total loss of sight of one or both eyes, or a partial loss of corrected vision of more than 75% bilaterally			Varicose veins
		Compressed air sequelae			Migraines			
		Deafness						

Explain all "Yes" answers. Please use back of form to give further explanation and details.

2. Primary care physician _____ Address _____

3. Have you ever injured or hurt your knee? Yes No Back? Yes No Neck? Yes No Shoulder? Yes No

If yes, did you receive treatment from a doctor? Yes No

Was surgery performed? Yes No If yes, when? _____ Where? _____

Name and address of doctor who performed the treatment _____

4. Have you ever received workers' compensation or disability benefits? Yes No If yes, please explain _____

5. Do you have, or have you ever had, any physical disability or impairment? Yes No If yes, please describe _____

Part of body? _____ Percentage of impairment? _____

I HAVE READ, AND FULLY UNDERSTAND, THIS FORM. I UNDERSTAND THAT MY FAILURE TO ANSWER TRUTHFULLY ANY OF THE ABOVE QUESTIONS MAY RESULT IN MY FORFEITURE OF ANY AND ALL WORKERS' COMPENSATION BENEFITS UNDER LA. REV. STAT. ANN. § 23:1208.1 (West 2007).

Your signature Date Witness's signature Date