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**John Bel Edwards**, Governor  
**Ava Dejeio**, Executive Director

**Office of Workers' Compensation Administration**  
Second Injury Board

## LA OWCA Second Injury Board Knowledge Questionnaire

The following questionnaire should only be completed by individuals that have been hired for employment. Your employer may ask that you complete this questionnaire following your initial hire and periodically thereafter.

The questionnaire may be used in the establishment of prior knowledge for the purpose of obtaining Second Injury Fund relief from the Second Injury Board. The Second Injury Board may reimburse your employer for workers' compensation claims that meet certain criteria should you become injured on the job. This reimbursement in no way affects the benefits owed to you by your employer or their insurance company under the Louisiana Workers' Compensation Act, La. R.S. 23:1021-1361.

### WARNING

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.**

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ Male:  Female:

Soc. Sec. # (last 4 digits only): \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone Number: ( \_\_\_\_ ) \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Please place a check in the appropriate box next to each medical condition listed below. Each illness or condition requires a Yes (Y) or No (N) answer. For all conditions that you check yes, write a brief explanation on the Explanation Page.

**Disease and Other Medical Conditions** [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Silicosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Parkinson's	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> Brain Damage	<input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input type="checkbox"/> Asbestosis	<input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> Double Vision	<input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning

**Surgical Treatment** [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N

- Spinal Disc Surgery                      Year (approximate if unsure) \_\_\_\_\_
- Spinal Fusion Surgery                      Year (approximate if unsure) \_\_\_\_\_
- Amputated Foot                      Left       Right       Year (approx. if unsure) \_\_\_\_\_
- Amputated Leg                      Left       Right       Year (approx. if unsure) \_\_\_\_\_
- Amputated Arm                      Left       Right       Year (approx. if unsure) \_\_\_\_\_
- Amputated Hand                      Left       Right       Year (approx. if unsure) \_\_\_\_\_
- Knee Replacement                      Left       Right       Year (approx. if unsure) \_\_\_\_\_
- Hip Replacement                      Left       Right       Year (approx. if unsure) \_\_\_\_\_
- Other Joint Replacement                      Joint \_\_\_\_\_      Year \_\_\_\_\_
- Other Surgical Procedure                      Procedure \_\_\_\_\_      Year \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**EXPLANATION PAGE**

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes     No

Are you taking medication for this condition?                      Yes     No

Do you have any permanent restrictions for this condition?                      Yes     No

Brief Explanation: \_\_\_\_\_

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CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes     No

Are you taking medication for this condition?                      Yes     No

Do you have any permanent restrictions for this condition?                      Yes     No

Brief Explanation: \_\_\_\_\_

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CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes     No

Are you taking medication for this condition?                      Yes     No

Do you have any permanent restrictions for this condition?                      Yes     No

Brief Explanation: \_\_\_\_\_

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CONDITION: \_\_\_\_\_ Year Diagnosed (approx): \_\_\_\_\_

Are you still treating for this condition?                      Yes     No

Are you taking medication for this condition?                      Yes     No

Do you have any permanent restrictions for this condition?                      Yes     No

Brief Explanation: \_\_\_\_\_

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Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes  No   
If "Yes," please list the restrictions: \_\_\_\_\_  
Were the restrictions: Permanent \_\_\_\_ Temporary \_\_\_\_  
Are you currently restricted? Yes  No   
What is the medical condition for which you are restricted? \_\_\_\_\_

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes  No

Please list the medical condition being treated: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

3. If you are presently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

Medication: \_\_\_\_\_ Prescribing Doctor: \_\_\_\_\_

4. Have you ever had an on the job accident? Yes  No   
If you answered "YES," please provide the date for each injury and the nature of the injury:

\_\_\_\_\_

How long were you on compensation? \_\_\_\_\_

Name of Employer: \_\_\_\_\_

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes  No   
If you answered YES, please provide:

Recommended surgery: \_\_\_\_\_

Approximate date of recommendation: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**WARNING**

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.**

**I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.**

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Printed: \_\_\_\_\_

**I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation Page as needed. I have confirmed the number of and labeled the pages of this questionnaire.**

Employer Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Witness Printed: \_\_\_\_\_

Title: \_\_\_\_\_