# LOUISIANA WORKERS’ COMPENSATION SECOND INJURY BOARD POST‐HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre‐ existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers’ Compensation Second Injury Board in the event you suffer an on‐the‐job injury.1 This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers’ Compensation Act. La. R.S. 23:1021‐1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers’ compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre‐existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

**EMPLOYEE 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.**

Employee Signature: Date:

Employer Representative Signature: Date:

Employer Name:

Employee Name:

Date of Birth (mm/dd/yyyy):

Male:  Female: 

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

Home Address:

Telephone Number:( )

1 Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re‐ employment, or retention of employees who have a permanent partial disability.

**Disease and Other Medical Conditions you currently have or have ever had.**

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

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

**Surgical Treatment** [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

**Y N**

|  |  |  |  |
| --- | --- | --- | --- |
| * Spinal Disc Surger | ry Year (approximate if unsure) | | |
| * Spinal Fusion Surg | gery 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 Replacemen | nt Left  | Right  | Year (approx. if unsure) |
| * Hip Replacement | Left  | Right  | Year (approx. if unsure) |
| * Other Joint Repla | cement Joint Year | | |
| * Other Surgical Pro | ocedure Procedure Year | | |
| * Other Surgical Pro | ocedure Procedure Year | | |
| * Other Surgical Pro | ocedure Procedure Year | | |
| * Other Surgical Pro | ocedure Procedure Year | | |

Employee Signature: Date:

Employer Representative: 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:

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:

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:

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:

Employee Signature: Date:

Employer Representative: 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 your activities currently restricted? Yes No 

What is the medical condition for which you have restrictions?

1. 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:

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

Medication: Prescribing Doctor:

Medication: Prescribing Doctor:

1. 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:

1. 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 Representative: Date:

# TO BE COMPLETED BY EMPLOYEE EMPLOYEE WARNING

**FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY**

# RESULT IN A FORFEITURE OF ANY AND ALL 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 Name:

# TO BE COMPLETED BY EMPLOYER REPRESENTATIVE EMPLOYER WARNING

**PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS’ COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.**

You must certify the following:

* 1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;
  2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;
  3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;
  4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and
  5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq*., or any other state or federal law;
  6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: Date:

Employer Representative Printed Name:

Title: