

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

Date: \_\_\_\_\_

Agency/Department: \_\_\_\_\_

Position: \_\_\_\_\_

**LOUISIANA SECOND INJURY FUND  
POST OFFER, PRE-EXISTING CONDITIONS, INJURIES OR ILLNESSES  
MEDICAL INQUIRY (E-2)**

**NOTICE TO EMPLOYEES:**

Your employer is committed to providing Workers' Compensation benefits, in accordance with state law, if you sustain an employment-related injury. This form requests medical information and will be kept confidential and separate from your personnel file. It will be used only in the event you experience a work-related injury and become eligible for Workers' Compensation benefits. The employer requires that all employees complete this questionnaire upon hire and every two years thereafter. The information is needed because if a work-related injury or disability is caused or made worse by a pre-existing condition, your employer may be able to seek reimbursement of the benefits paid from the Louisiana Second Injury Fund. This reimbursement would not reduce your workers' compensation benefits. In order to be considered for reimbursement, an employer must show it knowingly hired or knowingly retained an employee with a pre-existing disability. Disclosure of a pre-existing condition shall not be used for any discriminatory purpose. **THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION BENEFITS UNDER LA. R.S. 23:1208.1.**

**SECTION 1: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

Do not leave any blank unanswered. Please provide explanations for all "yes" responses under Remarks.

<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Amputation (foot, leg, arm, hand, or total loss thereof)	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Use of Limbs
<input type="checkbox"/>	<input type="checkbox"/>	Ankylosis of Joints	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	Muscle, Ligament or Tendon Injury
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Back/Neck Problem	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Brain Damage	<input type="checkbox"/>	<input type="checkbox"/>	Numbness of Extremities
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Psychoneurotic Disability
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Disease			(following treatment in a recognized medical or mental institution)
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Reflex Sympathetic Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Vascular Accident	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive Motion Injury
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Residual Disability from Polio
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Osteomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Compressed Air Sequelae	<input type="checkbox"/>	<input type="checkbox"/>	Rotator Cuff Injury
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ruptured Intervertebral Disc
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Silicosis
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision (blurred sight)	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Fusion
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Urine
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Removal of Intervertebral Disc
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition			Thrombophlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Heavy Metal Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic Outlet Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition
<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	

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|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hodgkin's Disease   | <input type="checkbox"/> | <input type="checkbox"/> | "Trick" Knee or Shoulder |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperinsulinism   | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis             |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension  | <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins           |
| <input type="checkbox"/> | <input type="checkbox"/> | Ionizing Radiation Injury   |                          |                          |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorder   |                          |                          |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Hearing (more than 75%)   |                          |                          |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Sight (of one or both eyes or a partial loss of uncorrected vision) |                          |                          |                          |

**REMARKS:** If you answered "yes" to any question above, indicate the nature of the injury/illness, name and address of the treating health care provider, area of specialty and approximate date/year of the illness/injury.

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**SECTION 2: PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE AS MUCH INFORMATION AS POSSIBLE.**

**1. Has any doctor ever restricted your activities due to injury, disability or medical condition?**

YES  NO

If yes, please describe the reason for the restrictions, the type of restrictions, whether the restrictions were temporary or permanent, and whether you presently have any restrictions on your physical activities.

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**2. Have you ever been assessed any percentage of permanent disability to any part of your body?**

YES  NO If yes, please explain:

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**3. Are you presently or have you ever been under the care of a doctor, chiropractor, or other health care provider for any serious injury, disability or medical condition?**

YES  NO

If yes, please list the condition, injury or illness(s) being treated, the name of the doctor(s), field of specialty, address and telephone number, and dates of treatment.

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**4. Are you presently or have you ever taken any medication for any serious injury, disability or medical condition?**

YES  NO

If yes, please list the name or type of medication, the medical condition being treated, and the name, address and telephone number of the physician who prescribed the medication, area of specialty, and dates of treatment.

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5. Have you ever had surgery (other than cosmetic) to any part of your body ?  YES  NO

If yes, please list the part(s) of the body operated on, the type of operation performed, the date (or approximate date), the hospital, and the name, address, and phone number of the doctor performing the surgery (if known).

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6. Have you ever received treatment for your head, neck, back or extremities (arms, wrists, legs, knees, etc.) from a doctor, chiropractor, physical therapist or other health care provider?

YES  NO

If yes, please list the name, address and phone number of all doctors, chiropractors, physical therapists, and other health care providers who provided such treatment, the dates of the treatment and the diagnosis provided.

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7. Are you aware of any physical condition or injury that might impair or limit your ability to work in this position?  YES  NO If yes, please describe the condition or injury.

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8. Have you ever received workers' compensation benefits for an injury that occurred at work?

YES  NO

If yes, please list the name of the employer, the nature of the injury and the dates, and the dates you received compensation.

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I HAVE READ ALL \_\_\_ PAGES OF THE LOUISIANA SECOND INJURY FUND POST OFFER OF EMPLOYMENT MEDICAL INQUIRY. I FULLY UNDERSTAND AND HAVE TRUTHFULLY AND FULLY ANSWERED ALL OF THE QUESTIONS, TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

**I UNDERSTAND THAT MY FAILURE TO TRUTHFULLY ANSWER ANY OF THE ABOVE QUESTIONS MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION STATUTE (LA.R.S. 23:1208.1).**

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_