LOUISIANA WORKFORCE COMMISSION

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Bobby Jindal, Governor
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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: Dieudonne Enterprises, Inc.

Employee Name: _____

Date of Birth: _____ Male: ____ Female: ____

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

Home Address: _____

Telephone Number: (_____) _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

Please place a check in the box next to medical conditions you currently have or have had previously. For all conditions that you check, write a brief explanation on the Explanation Page. No check mark in the box will indicate that you do not have nor have you ever had the corresponding condition.

Disease and Other Medical Conditions

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

Surgical Treatment

☐ 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 conditions that you checked 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 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: _____

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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: _____