LOUISIANA WORKFORCE COMMISSION

1001 North 23rd Street
Post Office Box 44187
Baton Rouge, LA 70804-4187

(O) 225-342-7866
800-201-2493
(F) 225-219-5968

Bobby Jindal, Governor
Curt Eysink, 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
☐ ☐ 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 Dystropy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertention	☐ ☐ 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 [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: ____

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: _____

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: _____