Employer Best Practices for LA Comp. No.1

HOW TO UTILIZE THE LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

PARKER & LANDRY

To illustrate the benefits of using this form, from December 2021 through September 2022, one of our clients who used the Second Injury Board Post-Hire/Conditional Job Offer Knowledge Questionnaire had two workers' compensation claims involving low back injuries. While one accident was unwitnessed and questioned by the employer, the other was a rear-end collision that no one questioned. Each employee had prior low back injuries involving lumbar disc herniations. Each employee completed the Second Injury Board Post-Hire/Conditional Job Offer Knowledge Questionnaire (from now on referred to as the "SIF medical history questionnaire") at the time of hire. However, both employees denied prior disc herniations on the form. The accidents in which they were later involved gave rise to the doctors' opinions that the new injuries merged with the old herniations to make the conditions worse in the classic "aggravation of a pre-existing condition" argument so prevalent in Louisiana to the frustration of employers.

Armed with the SIF medical history questionnaire with the denials of the prior herniations, we sought recovery from the Second Injury Board, knowing that the claims would be denied, as knowledge of the prior condition is an absolute requirement. The Second Injury Board) denied both claims for lack of knowledge on the employer's part, with all other requirements being satisfied during the application process. As the employees had not admitted to the prior conditions causing the employer to lose its Second Injury Fund claim, it gave rise to a fraud defense that the

The Louisiana Second Injury Board ("SIB") manages the Louisiana Second Injury Fund ("SIF"). The terms are used interchangeably when discussing the process.

employer could raise under Louisiana Revised Statute 23:1208.1. This form of fraud arises when the employee fails to disclose their medical history on the State's SIF medical history questionnaire. If the lack of knowledge of the pre-existing condition prevents the employer from satisfying the mandatory knowledge element, the employee loses their entire workers' compensation claim.

As a result, by use of a six-page form provided to those employees at the time of their hire, the employer, and the employer alone, set in motion a situation that allowed it to avoid nearly $200,000.00 in likely workers' compensation exposure in the form of a one-level lumbar discectomy surgery in one case and two-level lumbar fusion surgery in the other. The employer saved the cost of the surgeries and the exposure for future disability and additional medical benefits while still paying within their claim deductible. Since this form of fraud is **only** available if the misrepresentation by the employee is made on the specific form SIF medical history questionnaire, it was the employer's actions, and the employer's actions alone, that allowed us to move forward with the fraud defense under Louisiana Revised Statute R.S. 23:12081 ("1208.1 fraud"). The employer later gladly settled both cases for a total of $21,000.00.[1]

In Louisiana, our Second Injury Board will reimburse an employer for the benefits it pays in workers' compensation to an injured employee who is knowingly hired with a disability, and the employee later suffers an accident that merges with the original disability and creates a greater level of disability. After a specific amount of benefits are paid by the insurer – usually using your employer's money within its deductible – your employer can recover **100%** of future benefits it pays from the State[2]. Further, if the employer cannot satisfy the element that it "knowingly" hired an employee with a disability – if the employer used the proper questionnaire – and the employee did not disclose a qualifying disability, it will cost the employer

[1] Financially, the legal fees for prosecuting the fraud defense through trial would have exceeded that amount. The employer, the adjuster, and I decided it was best to settle the claims for two true cost-of-defense settlements.

[2] Reimbursement of indemnity begins after 104 weeks of disability payment and after $25,000 of related medical expenses have been paid.

its Second Injury Fund claim. If the employer loses its claim for reimbursement from the SIF because the employee failed to disclose their disability on the form, the employee loses their **right to all future** workers' compensation benefits under Louisiana Revised Statute 23:1208.1 (LSA-R.S. 23:1208.1).[3]

Would you further be surprised that nearly every Second Injury Fund or fraud claim under LSA-R.S. 23:1208.1 fails because the employer did not use the SIF medical history questionnaire or did not provide it correctly?

Think about it for a moment. For want of a completed six-page medical history questionnaire, you may have cost your employer its ability to recover most of the workers' compensation benefits paid in a high-dollar claim or cost it the ability to raise the almost unbeatable LSA-R.S. 23:1208.1 fraud defense. No form, no fraud. The SIF medical history questionnaire may be the **most valuable** tool for employers to defend against their workers' compensation claims.

WHAT IS THE SECOND INJURY FUND, AND WHY DOES IT MATTER?

Most states have a fund into which all employers and insurance companies pay to create a fund to reward – through reimbursement of workers' compensation benefits paid – employers who knowingly hire an employee with a disability. In Louisiana, this is the Second Injury Fund. By recognizing that an employee with a qualifying disability is at a greater risk for re-injury, reimbursement of future workers' compensation benefits by the Second Injury Fund is the reward granted to the employer for knowingly hiring someone with a disability.

Further, when we speak of a disability for the Second Injury Fund's purposes, we do not mean a complete and total disability. Instead, a disability – under the Second Injury Fund – is a condition that serves as an impediment or hindrance to future or continued employment. As understood by the Second Injury Fund, certain diseases and medical conditions automatically qualify as a permanent, partial disability

[3] As of August 26, 2022, the author was responsible for 82 workers' compensation defense claims. Of those 82, 53 involved back or neck injuries as the most common primary complaint. The Second Injury Fund Post-Hire/Conditional Job Offer History Questionnaire was used by employers in 9 of those claims.

(PPD), the phrase used to describe conditions automatically accepted as a possible hindrance to employment.

The SIF medical history questionnaire lists 52 different permanent, partial disabilities. Of the 52 various permanent, partial disabilities that automatically qualify, you will find among that list such common medical issues as diabetes, hearing loss, migraine headaches, and arthritis, to name a few of those conditions that qualify. Given what we see in our practices, two listed conditions occur with such frequency that they likely form 95% of all the Second Injury Fund claims filed each year – "Ruptured or herniated disc" and "Carpal Tunnel Syndrome." A herniated disc is typical in most adults at some point in their lives, so the question about "Ruptured or herniated disc" is the most frequent disability you will encounter. As the legal threshold to support the aggravation of a pre-existing medical condition such as a prior herniated disc is so low, well over 50% of the author's current workers' compensation claims involve a herniated cervical (neck) or lumbar (low back) disc. Consequently, these claims involve the possibility of Second Injury Fund recovery or fraud under LSA-R.S. 23:1208.1, but **only** if the employer properly utilizes the SIF medical history questionnaire.

An unlisted condition that adversely affects the employee's ability to find employment can serve as an appropriate disability, but an unlisted disability requires much more information.

The availability of these two benefits – Second Injury Fund recovery or fraud under LSA-R.S. 23:1208.1 –exists only if the proper form is used.

WHAT IS NEEDED FOR SECOND INJURY FUND RECOVERY?

Simply employing someone with a proper disability and utilizing the form does not automatically allow you to recover from the Second Injury Fund. The law specifically requires that a later work-related accident merges with the known disability to make that disability worse. Therefore, there is no reimbursement if the work-related accident injures a body part other than the known disabling condition.

To apply for recovery from the Second Injury Fund, an employer **must** prove:

(1) The knowledge that the employee had a Permanent Partial Disability or a disabling condition which can be proven to be a hindrance to employment before the accident. This knowledge can be satisfied in two ways:
   a. A Second Injury Board Post-Hire/Conditional Job Offer Knowledge Questionnaire completed by the employee before the date of the accident, or
   b. Having a separate employee capable of completing an Affidavit of Knowledge. The affidavit requires that (1) the employee completing the affidavit has higher/fire authority, (2) who was familiar with the physical requirements of the job of the employee who suffered the work-related accident, (3) who was aware of the disabling condition before the accident, and (4) who can attest to an accommodation having been made for the employee's disabling condition before the accident. The affidavit is generally used for an employee who suffered their Permanent Partial Disability/condition serving as a hindrance to employment while already employed with the employer.

(2) The employee suffered a work-related accident and injury to the disclosed Permanent Partial Disability/condition serving as a hindrance to employment, and

(3) Medical evidence to support that the accident and injury "merged with" the original Permanent Partial Disability/disabling condition to create a greater level of disability.

As you may grasp, without the employer having the "knowledge" element satisfied, the examination goes no further, and the claim for reimbursement will fail.

While your attorney can assist you in obtaining the affidavit, if possible, and will satisfy element number two and number three above, SIF medical history questionnaire can only be provided by **you**, as it is provided at the time of hire. Critically, only the SIF medical history questionnaire has the LSA-R.S. 23:1208.1 fraud language.

HOW TO PROPERLY USE THE LOUISIANA SECOND INJURY FUND POST-HIRE MEDICAL HISTORY QUESTIONNAIRE FORM

Since the Americans with Disabilities Act (ADA) of 1990 prevents you from asking about an employee's medical history or disabilities before hiring – as it prevents the risk of abuse for discriminating against employees with disabilities – this form **must** be presented to the employee **after** you have extended the offer of hire to the employee. Also known as a "conditional hire," this form is used **only** to help the employer apply for Second Injury Fund recovery. Use of this specific form for **any** other purpose is prohibited.

Can the SIF medical history questionnaire form be provided to a current employee? The is no solid answer. Read broadly, asking about a current employee's disabilities would run afoul of the ADA. But Louisiana Revised Statute 23:1371(A) states that the purpose of the Second Injury Fund is to encourage the employment, "reemployment or retention of employees…" The two rules obviously do not agree. Therefore, using the SIF medical history questionnaire with current employees may present a risk. It would be best if you spoke with an employment law attorney to weigh the risk of using the SIF medical history questionnaire with current employees.

Whether a new employee or a current employee completed the form, the SIF medical history questionnaire, and its information should be protected from disclosure. Only the person(s) responsible for using such information due to their position in human resources, risk management, etc., within your company should have access to this information. The forms should be placed in a sealed envelope. Following a work-related accident, only those directly involved in your company's workers' compensation claim management should open the form. A copy of this SIF medical history questionnaire or information to satisfy the affidavit should be provided to your workers' compensation adjuster, as there are time limits to apply for recovery from the Second Injury Fund.

Your adjuster or attorney will soon report whether there is the potential for Second Injury Fund recovery or fraud under LSA-R.S. 23:1208.1.

THE MATERIALS ATTACHED

This introduction section is addressed to those individuals with your company who will implement the use of the form. The next section entitled "HOW TO USE THE LOUISIANA SECOND INJURY BOARD POST-HIRE/CONDITIONAL JOB OFFER KNOWELDGE FORM" and is an instructional guide for whomever's job it is with your company to provide the form to your new employees. It also contains a glossary of the medical terms used in the form for the individual presenting the form to answer any questions asked. A separate copy of the same glossary is provided to present to the employee to assist in their compenting the form. This will prevent the employee from later claiming that they misunderstood a term on the form. A copy of the form in English and then in Spanish follows.

PARTING THOUGHTS

Suppose an employee had a prior medical condition before being hired, and they were later involved in a work-related accident that worsened that medical condition. In that case, **nothing** prevents that employee from bringing a workers' compensation claim. That prior medical condition may be **a factor** the court considers in deciding whether to rule in the employee's favor. Still, it does not mean that the employer automatically wins at trial. In Louisiana, in most situations, if a work-related accident aggravates a prior, non-work-related medical condition, the employer is responsible for payment of the entirety of the injury, including the old condition and the new injury. But your employer may receive reimbursement from the Second Injury Fund if the employee completes the Louisiana Workers' Compensation Second Injury Board Post-Hire/Conditional Job Offer Knowledge Questionnaire.

Also, fraud in Louisiana for workers' compensation requires we prove the employee's knowledge of their fraudulent actions, and the Louisiana Workers' Compensation Second Injury Board Post-Hire/Conditional Job Offer Knowledge Questionnaire warns the employee in advance that:

> **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.**

So, assuming the accident is an aggravation injury, if the employee lied on the form originally, the knowledge element is satisfied by their having read this language and not admittied to the condition days, weeks, months, or years in advance. So do not fool yourself into believing this is just another form that serves no purpose.

If prepared correctly, your employer will have a viable Second Injury Fund claim entitling it to significant reimbursement for the benefits it pays or a solid fraud defense under LSA-R.S. 23:1208.1. That is a fantastic return for a six-page form, assuming the employee was asked to complete that form in the first place.

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HOW TO USE THE LOUISIANA SECOND INJURY BOARD POST-HIRE/CONDITIONAL JOB OFFER KNOWELDGE FORM

Perhaps the most important rule is that the form **should never** be provided to employees until you have offered them the position. Otherwise, there will be a risk of violating the Americans with Disabilities Act (ADA).

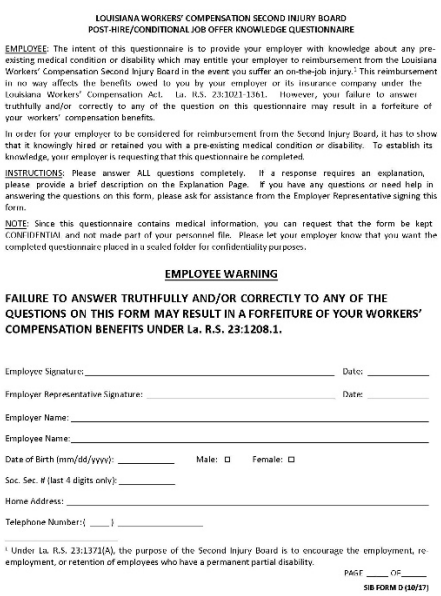
Based upon past mistakes made by other employers when using this form to allege fraud under LSA-R.S. 23:1208.1, we recommend that you implement the following policies.

- The employee must answer every single question. If a question does not apply to the employee, they need to place in the blank "N/A" for "not applicable." Having a response to every question will prevent an employee who intentionally skips a vital question from claiming they did not see it.
- After the first page, each subsequent page will require the employee's signature and the corresponding signature of the person who presents that form to the employee. The person giving the form to the employee must watch the employee complete the form and then sign each page at the bottom after they have watched the employee complete the entire document. This action prevents the employee from saying that they were given the form to take home and that someone else completed the form for them. It also allows us to argue that the employer's representative was available to answer any questions asked by the employee. The employer's representative should instruct employees to print their names under their signatures to aid against authenticity challenges.
- Once completed, the representative giving the form to the employee must read the document and ensure every question has been answered and every box checked appropriately.
- The employer's representative should place the document into a sealed envelope within the employee's personnel file. Please put it in a sealed envelope to be opened only by the human resources department, the risk manager, or whoever is responsible for handling compensation claims with your company when the employee suffers an accident.
- Once the employee suffers an accident, your workers' compensation insurer should be given a copy, so they can begin the process of seeking Second

Injury Fund recovery if appropriate.

- You must complete the page count at the bottom of each page.

Page One



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.

PAGE ____ OF____

SIB FORM D (10/17)

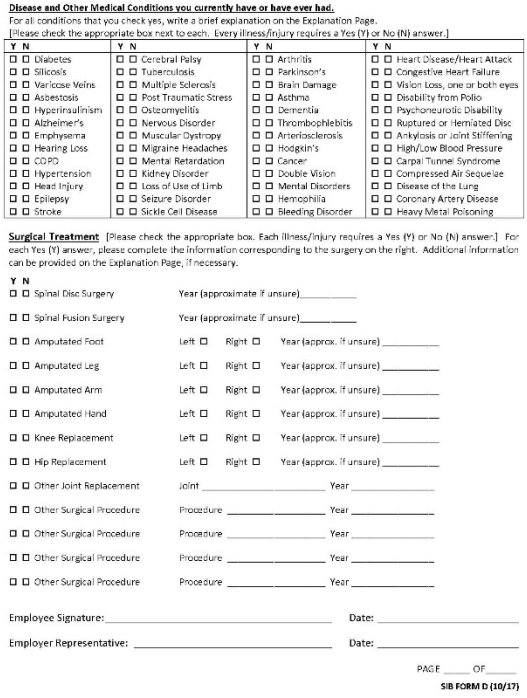
Page One will explain why the employee is asked to complete the form. This explanation will prevent the employee from claiming they were unaware of the form's purpose. The explanation paragraph was added in the recent document version to address that specific argument.

The paragraph in bold is the all-important warning language under LSA-R.S. 23:1208.1. It explains very clearly to the employee that not being truthful in their responses may result in a complete loss of any future workers' compensation benefits. It is this language alone that gives us the ability to utilize this form of fraud. The remainder of the page includes general demographic information for the employee.

Page Two

The second page begins by asking the employee about their medical history. You must make the employee aware that this questionnaire concerns any medical condition regardless of the cause or whether they are currently treating for this condition. This warning prevents the employee from arguing later that they thought the questionnaire applied only to prior work-related accidents.

The conditions in the box automatically qualify as 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	☐	☐	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
☐	☐	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 [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 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 _____
☐	☐	Other Surgical Procedure	Procedure _____ Year _____
☐	☐	Other Surgical Procedure	Procedure _____ Year _____
☐	☐	Other Surgical Procedure	Procedure _____ Year _____

Employee Signature:_____ Date: _____

Employer Representative: _____ Date: _____

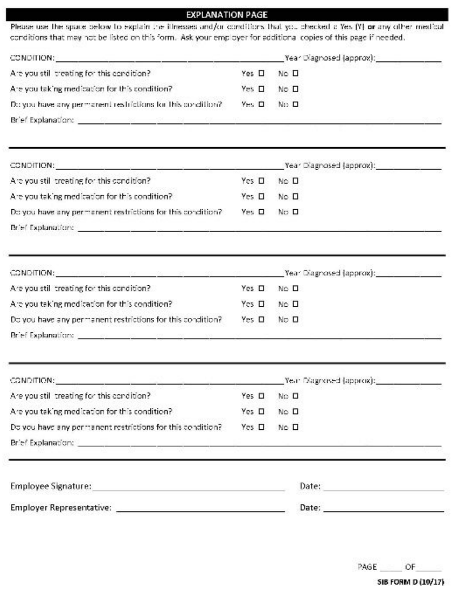
PAGE ____ OF____

SIB FORM D (10/17)

conditions commonly subject to aggravation in a later workers' compensation accident.

The second section concerns prior surgical procedures that the employee may have undergone in the past. Again, note the signature blanks at the bottom.

Page Three



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: ____

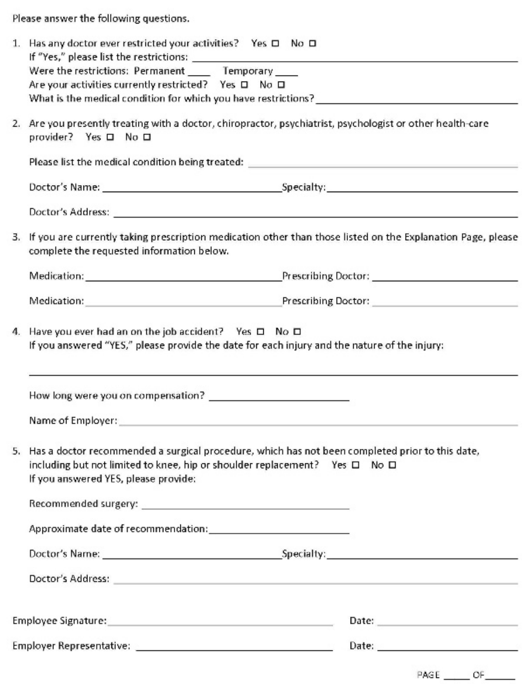
Employee Signature: ____ Date: ____
Employer Representative: ____ Date: ____

PAGE ____ OF ____
SIB FORM D (10/17)

This page goes into detail about specific medical conditions. They may include an explanation of the conditions on page 2, or they can be separate medical conditions that did not satisfy any of the questions on page 2. As noted in the instructions, provide additional copies of this page to the employee if needed. Again, note the signature blanks at the bottom.

Page Four

Since your adjuster or attorney will later have to locate the medical information to support the existence of the original condition upon which the claim for Second Injury Fund recovery is based, page 4 asks questions about the employee's ongoing medical treatment. For example, it seeks information about prior work restrictions, prior on-the-job accidents, the names of the doctors with whom the employee is currently treating, and any prescription medication they are taking. It ends by asking the employee if they are presently



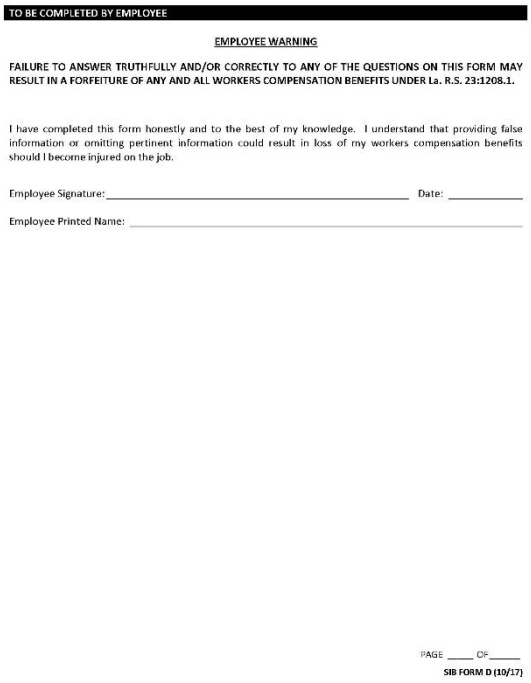
Please answer the following questions.

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? ____
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 currently 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 Representative: ____ Date: ____

PAGE ____ OF ____
SIB FORM D (10/17)

awaiting any surgical procedures. As with the preceding pages, the signature blanks are located at the bottom of the form.



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: _____

PAGE _____ OF_____

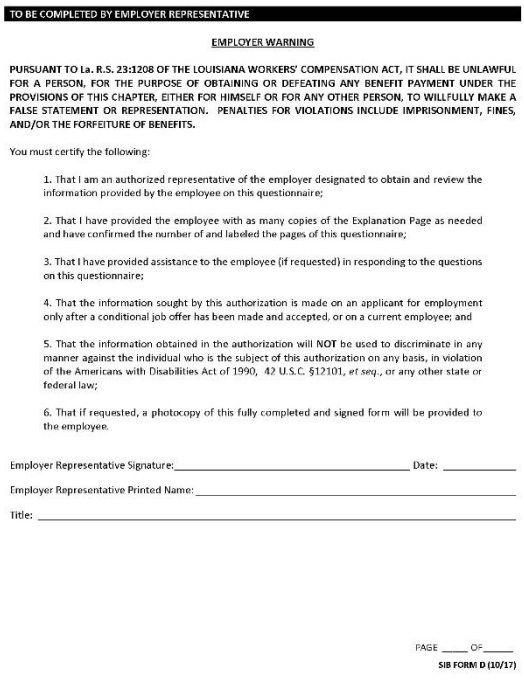
SIB FORM D (10/17)

Page Five

This page again reminds the employee that failure to disclose their medical history could cause them to forfeit any future potential workers' compensation benefits. Finally, this page concludes with the employee signing and printing their name, acknowledging that they have completed the form to the best of their knowledge. The warning about the risk of failing to disclose their medical history is repeated here.

Page Six

On the right, you will see that page 6 is prepared specifically for the employer's benefit. These warnings are the most recent addition to the questionnaire. It illustrates to the employer that it can also be subject to fraud under a different provision, Louisiana Revised Statute, LSA-R.S. 23:1208 if it intentionally misrepresents anything on this form or assists another in misrepresenting anything on the form.



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: _____

PAGE _____ OF_____

SIB FORM D (10/17)

There are also six specific conditions to which the employer's representative must attest. For example, the employer's representative must certify that they are authorized to take and review the information, that they provided the employee as many copies of the

forms as necessary, that they assisted the employee in answering the questions, that the request for the information occurred after the conditional job offer had been extended to the employee, that the employer will not use the information to discriminate against the employee, and that the employee will receive a copy.

The Louisiana Office of Workers' Compensation recently created a Spanish version of the SIF medical history questionnaire.

Glossary of Diseases and Medical Conditions from Page 2

Some of the conditions listed on page 2 of the form are ones with which you will be familiar. Unfortunately, there are conditions listed for which more information is needed than is supplied by the form. You should be familiar with the 52 listed conditions to answer any questions the employee asks. A brief description of these conditions is listed below. They are presented in alphabetical order for ease of reference rather than as they are listed on the form. A separate glossary is provided to give to the employee.

Alzheimer's – A gradually progressive brain disorder causing memory, thinking, and behavior problems.

Ankylosis or Joint Stiffening – An abnormal stiffening and immobility of a joint due to fusion of the bones.

Arteriosclerosis – A thickening of the blood vessels that carry oxygen and nutrients from the heart to the rest of the body.

Arthritis – A general term for a condition with swelling and tenderness of one or more joints in the body with accompanying pain and stiffness.

Asbestosis – Long-term exposure to asbestos fibers that cause lung scarring and breathing difficulty.

Asthma – A lung disorder characterized by narrowing the airways that carry air to the lungs.

Bleeding Disorder – A broad category covering any form of bleeding disorder other than hemophilia, a separate category.

Brain Damage – A broad category covering any injury to the brain.

Cancer – A general term for any cancer of the body not otherwise listed. Cancer is

generally recognized as an uncontrolled growth of the body cells that spreads to other body parts.

Carpal Tunnel Syndrome – A wrist condition caused by a compression of the medial nerve resulting in pain, tingling, and numbness in the hand or base of the palm.

Cerebral Palsy – A collection of neurological disorders that affect movement, muscle tone, balance, and posture.

Coronary Artery Disease – A condition where the major blood vessels that supply the heart with blood are narrowed, resulting in chest pain or shortness of breath.

Compressed Air Sequelae – Damage to the lungs, ruptured eardrum, etc. due to air concussion, blasting, or explosions.

Congestive Heart Failure – A progressive disease that affects the pumping action of the heart muscles.

COPD – "Chronic Obstructive Pulmonary Disease" is characterized by persistent breathing problems, including breathlessness and coughing.

Diabetes – A condition resulting from the body's insufficient insulin production resulting in high blood sugar.

Disease of the Lung – A broad category covering any disease of the lungs not covered by a more specific disability on the list.

Disability from Polio – A disability resulting from severe paralysis due to the poliovirus.

Double vision – A condition of the eye causing two overlapping images instead of a single, typical image.

Dementia – A group of symptoms that affect memory and thinking and interfere with daily life.

Emphysema – A condition resulting in shortness of breath due to the destruction of the internal structures of the lung.

Epilepsy – A neurological disorder that causes seizures are unusual sensations and behaviors.

Hearing Loss – A loss of hearing not dependent upon any specific cause.

Heart Disease/Heart Attack – A broad category covering any condition that affects the structures or function of the heart, including high cholesterol. A heart attack is damage to the heart muscle caused by a sudden loss of blood supply.

Head Injury – A broad category covering any injury to the skull.

Heavy Metal Poisoning – A general term for any poisoning from introducing a heavy metal into the bloodstream. Common examples include lead poisoning and mercury poisoning.

Hemophilia – A condition in which the blood does not normally clot.

High/Low Blood Pressure – High blood pressure is the condition reflecting the long-term damage caused by the flow of blood against your arterial walls. Low blood pressure is an insufficient blood flow pressure causing problems with the normal functioning of the heart and arteries.

Hyperinsulinism – A condition caused by the body's overproduction of insulin. Hypertension -The technical term for high blood pressure.

Hodgkin's – A immune system cancer often noted by enlarged lymph nodes.

Kidney Disorder – A broad category covering any disorders associated with the kidneys, including, but not limited to, kidney (renal) failure.

Loss of Use of Limb – A partial or complete loss of an arm, leg, or all.

Mental Disorders – A vast category of conditions that cause psychological and behavioral disturbances of varying severities. This category would also include conditions such as depression and anxiety.

Migraine Headaches – A condition identified by occasional suffering of headaches with severe throbbing pain, often on one side of the head.

Mental Retardation – More commonly referred to as an intellectual disability, this is a condition in which an individual has a below-average general intellectual function and difficulty learning basic skills necessary for daily living.

Multiple Sclerosis – A condition of the nervous system that causes difficulties for the brain to send signals to the rest of the body. This often results in difficulty controlling movement in the extremities.

Muscular Dystrophy – A group of conditions affecting the muscles, gradually leading to disability.

Nervous Disorder – A general category covering any condition of the brain, spinal cord, autonomic or peripheral nerves.

Osteomyelitis – An infection of the bone caused by bacteria or fungi.

Parkinson's Disease – A chronic and progressive movement disorder that causes tremors in the hands or stiffness or slowing of movement.

Psychoneurotic Disability – A mental disorder involving mental distress without delusions or hallucinations with behavior outside socially acceptable norms.

Post-Traumatic Stress – A severe mental health condition developing following traumatic events, including intrusive thoughts about the incident and severe anxiety.

Ruptured or Herniated Disc – A condition resulting from a rupture/herniation of the discs between the spinal column's bones. The soft inner portion of the disc protrudes outside the hard outer lining (the annulus).

Seizure Disorder – A condition resulting in sudden, uncontrolled electrical disturbances in the brain causing changes in behavior, movements, feelings, and consciousness.

Sickle Cell Disease – A disorder of the red blood cells causing the red blood cells to change shape resulting in difficulty in the movement of the red blood cells throughout the body.

Silicosis – Long-term exposure to silica dust (a sand component) that causes lung scarring and breathing difficulty.

Stroke – A condition caused by a loss of supply to the brain causing brain tissue damage.

Thrombophlebitis – A condition where inflammation in a vein is caused by a blood clot adversely affecting normal blood flow. This condition usually occurs in the legs.

Tuberculosis – An infection caused by bacteria in the lungs and other organs. Common symptoms include a persistent cough or blood produced when coughing.

Varicose Veins – A condition occurring when the veins become enlarged and overfilled with blood.

Vision Loss, one or both eyes – A condition resulting in a loss of vision in one or both eyes.

GLOSSARY OF CONDITIONS ON PAGE TWO

GLOSSARY OF DISEASES AND MEDICAL CONDITIONS FROM PAGE TWO

To be presented to the employee with the questionnaire

Below you will find a brief description of the conditions found on Page Two of the Louisiana Workers' Compensation Second Injury Board Post-Hire/Conditional Job Knowledge Questionnaire. We have presented the conditions in alphabetical order.

Alzheimer's – A gradually progressive brain disorder causing memory, thinking, and behavior problems.

Ankylosis or Joint Stiffening – An abnormal stiffening and immobility of a joint due to fusion of the bones.

Arteriosclerosis – A thickening of the blood vessels that carry oxygen and nutrients from the heart to the rest of the body.

Arthritis – A general term for a condition with swelling and tenderness of one or more joints in the body with accompanying pain and stiffness.

Asbestosis – Long-term exposure to asbestos fibers that cause lung scarring and breathing difficulty.

Asthma – A lung disorder characterized by narrowing the airways that carry air to the lungs.

Bleeding Disorder – A broad category covering any form of bleeding disorder other than hemophilia, a separate category.

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Carpal Tunnel Syndrome – A wrist condition caused by a compression of the medial nerve resulting in pain, tingling, and numbness in the hand or base of the palm.

Cerebral Palsy – A collection of neurological disorders that affect movement, muscle tone, balance, and posture.

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Congestive Heart Failure – A progressive disease that affects the pumping action of the heart muscles.

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Double vision – A condition of the eye causing two overlapping images instead of a single, typical image.

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Emphysema – A condition resulting in shortness of breath due to the destruction of the internal structures of the lung.

Epilepsy – A neurological disorder that causes seizures are unusual sensations and behaviors.

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Hyperinsulinism – A condition caused by the body's overproduction of insulin. Hypertension -The technical term for high blood pressure.

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Loss of Use of Limb – A partial or complete loss of an arm, leg, or all.

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Migraine Headaches – A condition identified by occasional suffering of headaches with severe throbbing pain, often on one side of the head.

Mental Retardation – More commonly referred to as an intellectual disability, this is a condition in which an individual has a below-average general intellectual function and difficulty learning basic skills necessary for daily living.

Multiple Sclerosis – A condition of the nervous system that causes difficulties for the brain to send signals to the rest of the body. This often results in difficulty controlling movement in the extremities.

Muscular Dystrophy – A group of conditions affecting the muscles, gradually leading to disability.

Nervous Disorder – A general category covering any condition of the brain, spinal cord, autonomic or peripheral nerves.

Osteomyelitis – An infection of the bone caused by bacteria or fungi.

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delusions or hallucinations with behavior outside socially acceptable norms.

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Varicose Veins – A condition occurring when the veins become enlarged and overfilled with blood.

Vision Loss, one or both eyes – A condition resulting in a loss of vision in one or both eyes.

LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

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	☐ ☐ 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
☐ ☐ 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 [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 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 _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

☐ ☐ Other Surgical Procedure 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? _____

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 currently 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 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: _____

LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

(in Spanish)

COMPENSACION A LOS TRABAJADORES DE LOUISIANA
SEGUNDA JUNTA DE LESION

CUESTIONARIO DE CONOCIMIENTO LABORAL SUBSIGUIENTE/OFERTA DE TRABAJO CONDICIONAL

EMPLEADO: La intención de este cuestionario es proporcionar a su empleador conocimiento sobre cualquier afección médica o discapacidad preexistente que puede darle derecho a su empleador a reembolso de la Compensación a los Trabajadores de Louisiana Segunda Junta de Lesión en caso que sufra una lesión en el trabajo.[1] Este reembolso no afecta de ningúna manera los beneficios adeudados a usted por su empleador o su compañia de seguros bajo el Acta de Compensación a los Trabajadores de Louisiana. La. R.S. 23:1021-1361. Sin embargo, si usted no contesta con veracidad y/o correctamente a cualquier pregunta en este cuestionario puede resultar en una pérdida de sus beneficios de compensación a los trabajadores.

Para que su empleador pueda ser considerado para el reembolso de la Segunda Junta de Lesión, tiene que demostrar que usted fue contratado o retenido en el trabajo con conocimiento de una afección médica o discapacidad preexistente. Para establecer su conocimiento, su empleador debe solicitar que usted complete este cuestionario.

INSTRUCCIONES: Por favor, conteste TODAS las preguntas de forma completa. Si una respuesta requiere una explicación, por favor proporcione una breve descripción en la Página de Explicación. Si tiene cualquier pregunta o necesita ayuda para responder a las preguntas de este formulario, por favor solicite ayuda al Representante del Empleador que firmó este formulario.

NOTA: Dado que este cuestionario contiene información médica, usted puede solicitar que el formulario se mantenga CONFIDENCIAL y no forme parte de su expediente personal/archivo personal. Por favor, hágale saber a su empleador que usted desea que su cuestionario completo sea colocado en un folder sellado para propósitos de confidencialidad.

ADVERTENCIA AL EMPLEADO

LA FALTA DE RESPUESTA VERAZ Y/O CORRECTA A CUALQUIERA DE LAS PREGUNTAS DE ESTE FORMULARIO PUEDE RESULTAR EN LA CONFISCACION DE SUS BENEFICIOS DE COMPENSACION A LOS TRABAJADORES BAJO LA LEY La. R.S. 23:1208.1.

Firma del Empleado:_____ Fecha: _____

Firma del Representate del Empleador:_____ Fecha: _____

Nombre del Empleador:_____

Nombre del Empleado:_____

Fecha de Nacimiento (mes/dia/año):_____ Hombre: ☐ Mujer: ☐

Seguro Social (solamente los últimos 4 dígitos): _____

Dirección de Domicilio: _____

Número de Teléfono: (_____) _____

[1] Bajo la Ley La. R.S. 23:1371(A), el propósito de la Segunda Junta de Lesión es motivar el empleo, el re-empleo, o la retención de los empleados que tienen una discapacidad parcial permanente.

Enfermedades y Otras Condiciones Médicas que Usted tiene actualmente o que ha tenido.

Para todas las condiciones que usted marque Sí (S), escriba una breve explicación en la Página de Explicación.

[Por favor, ponga una marca en la casilla apropiada inmediatamente al lado de cada condición médica que se enumera a continuación. Cada enfermedad o condición médica requiere de un Sí (S) o un No (N) por respuesta.]

S	N		S	N		S	N		S	N	
☐	☐	Diabetes	☐	☐	Parálisis Cerebral	☐	☐	Artritis	☐	☐	Enfermedad del Corázon/Ataque Cardíaco
☐	☐	Silicosis	☐	☐	Tuberculosis	☐	☐	Enfermedad de Parkinson	☐	☐	Insuficiencia Cardíaca Congestiva
☐	☐	Venas Varicosas	☐	☐	Esclerosis Múltiple	☐	☐	Daño Cerebral	☐	☐	Pérdida de la Visión, de uno o de ambos ojos
☐	☐	Asbestosis	☐	☐	Estrés Postraumático	☐	☐	Asma	☐	☐	Incapacidad debido a la Polio
☐	☐	Hiperinsulinismo	☐	☐	Osteomielitis	☐	☐	Demencia	☐	☐	Discapacidad Psiconeurótica
☐	☐	Alzheimer	☐	☐	Trastorno Nervioso	☐	☐	Tromboflebitis	☐	☐	Disco Roto o Herniado
☐	☐	Enfisema	☐	☐	Distrofia Muscular	☐	☐	Arteriosclerosis	☐	☐	Anquilosis o Rigidez Articular
☐	☐	Pérdida Auditiva	☐	☐	Dolores de Cabeza producidos por la Migraña	☐	☐	Enfermedad de Hodgkin	☐	☐	Presión Arterial Alta/Baja
☐	☐	COPD:Enfermedad de Obstrucción Pulmonar Crónica	☐	☐	Discapacidad Intelectual	☐	☐	Cancer	☐	☐	Síndrome del Túnel Carpiano
☐	☐	Hipertensión	☐	☐	Trastorno Renal	☐	☐	Visión Doble	☐	☐	Secuela de Aire Comprimido
☐	☐	Traumatismo Craneal	☐	☐	Pérdida del Uso de la Extremidad	☐	☐	Trastornos Mentales	☐	☐	Enfermedad del Pulmón
☐	☐	Epilepsia	☐	☐	Convulsiones	☐	☐	Hemofilia	☐	☐	Enfermedad de las Arterias Coronarias
☐	☐	Derrame Cerebral	☐	☐	Enfermedad de Células Falciformes	☐	☐	Sangrado, Trastorno Hemorrágico	☐	☐	Envenenamiento por los Metales Pesados

Tratamiento Quirúrgico [Por favor, marque la casilla apropiada. Cada enfermedad/lesión requiere de una respuesta Sí (S) o No (N).] Para cada respuesta Sí (S), por favor complete la información correspondiente a la cirugía en el lado derecho. Información adicional puede ser proporcionada en la Página de Explicación, si es necesario.

S	N				
☐	☐	Cirugía del Disco Espinal	Año (aproximado si no está seguro) _____		
☐	☐	Cirugía de Fusión Espinal	Año (aproximado si no está seguro) _____		
☐	☐	Pie Amputado	Izquierdo ☐	Derecho ☐	Año (aprox. si no está seguro) _____
☐	☐	Pierna Amputada	Izquierda ☐	Derecha ☐	Año (aprox. si no está seguro) _____
☐	☐	Brazo Amputado	Izquierdo ☐	Derecho ☐	Año (aprox. si no está seguro) _____
☐	☐	Mano Amputada	Izquierda ☐	Derecha ☐	Año (aprox. si no está seguro) _____
☐	☐	Reemplazo de la Rodilla	Izquierda ☐	Derecha ☐	Año (aprox. si no está seguro) _____
☐	☐	Reemplazo de la Cadera	Izquierda ☐	Derecha ☐	Año (aprox. si no está seguro) _____
☐	☐	Otro reemplazo de Articulación	Articulación _____		Año _____
☐	☐	Otro Procedimiento Quirúrgico	Procedimiento _____		Año _____
☐	☐	Otro Procedimiento Quirúrgico	Procedimiento _____		Año _____
☐	☐	Otro Procedimiento Quirúrgico	Procedimiento _____		Año _____
☐	☐	Otro Procedimiento Quirúrgico	Procedimiento _____		Año _____

Firma del Empleado: _____ Fecha: _____

Representante del Empleador: _____ Fecha: _____

PAGINA DE EXPLICACION

Por favor, use el espacio a continuación para explicar las enfermedades y/o condiciones que usted marcó como SÍ (S) **u** cualquier otra(s) condición(es) médica(s) que no esté en la lista de este formulario. Pídale a su empleador copias adicionales de esta página, si es necesario.

CONDICIÓN:______________________________________ Año del Diagnóstico (aprox): __________

¿Todavía está usted bajo tratamiento por esta condición? Sí ☐ No ☐

¿Está usted tomando medicinas por esta condición? Sí ☐ No ☐

¿Tiene usted cualquier restricción permanente por esta condición? Sí ☐ No ☐

Explicación Breve: ____

____

CONDICIÓN:______________________________________ Año del Diagnóstico (aprox): __________

¿Todavía está usted bajo tratamiento por esta condición? Sí ☐ No ☐

¿Está usted tomando medicinas por esta condición? Sí ☐ No ☐

¿Tiene usted cualquier restricción permanente por esta condición? Sí ☐ No ☐

Explicación Breve: ____

____

CONDICIÓN:______________________________________ Año del Diagnóstico (aprox): __________

¿Todavía está usted bajo tratamiento por esta condición? Sí ☐ No ☐

¿Está usted tomando medicinas por esta condición? Sí ☐ No ☐

¿Tiene usted cualquier restricción permanente por esta condición? Sí ☐ No ☐

Explicación Breve: ____

____

CONDICIÓN:______________________________________ Año del Diagnóstico (aprox): __________

¿Todavía está usted bajo tratamiento por esta condición? Sí ☐ No ☐

¿Está usted tomando medicinas por esta condición? Sí ☐ No ☐

¿Tiene usted cualquier restricción permanente por esta condición? Sí ☐ No ☐

Explicación Breve: ____

Firma del Empleado: ______________________________ Fecha: ____________________

Firma del Represente del Empleador: ____________________ Fecha: ____________________

Por favor, conteste las siguientes preguntas:

1. Alguna vez, algún doctor ha restringido sus actividades? Sí ☐ No ☐
   Si es "Sí," por favor haga una lista de sus restricciones: _____
   ¿Eran las restricciones: Permanentes ____ Temporales ____
   ¿Está usted con alguna restricción en este momento? Sí ☐ No ☐
   ¿Cual es la condición médica por la cual usted esta restringido? _____

2. ¿Está usted actualmente siendo tratado por un médico, quiropráctico, psiquiatra, psicólogo, u otro proveedor de los cuidados de la salud? Sí ☐ No ☐

   Por favor, enumere las condiciones médicas por las cuales usted está siendo tratado: _____

   Nombre del Médico: _____ Especialidad: _____

   Dirección del Médico: _____

3. Si usted está actualmente tomando alguna otra prescripción médica diferente a aquellas en la lista de la Página de Explicación, por favor complete a continuación, la información requerida:

   Medicinas: _____ Médico que la recetó: _____

   Medicinas: _____ Médico que la recetó: _____

4. ¿Ha tenido usted alguna vez un accidente en el trabajo? Sí ☐ No ☐
   Si usted contestó que"SI," por favor, proporcione la fecha de cada accidente y la naturaleza de la lesión:
   _____

   ¿Por cuanto tiempo estuvo usted recibiendo compensación? _____

   Nombre del Empleador: _____

5. ¿Ha recomendado el médico un procedimiento quirúrgico, el cual no ha sido completado previamente a esta fecha, incluyendo pero no limitado al reemplazo de la rodilla, cadera u hombro? Sí ☐ No ☐
   Si usted contestó que SI, por favor proporcione la siguiente información:

   Cirugía recomendada: _____

   Fecha aproximada de la recomendación: _____

   Nombre del Médico: _____ Especialidad: _____

   Dirección del Médico: _____

Firma del Empleado: _____ Fecha: _____

Firma del Representante del Empleador: _____ Fecha: _____

PARA SER COMPLETADO POR EL EMPLEADO

ADVERTENCIA AL EMPLEADO

AL NO CONTESTAR EN FORMA VERDADERA Y/O CORRECTAMENTE A CUALQUIERA DE ESTAS PREGUNTAS EN ESTE FORMULARIO PUEDE RESULTAR EN LA PERDIDA O LA CONFISCACION DE LOS BENEFICIOS DE COMPENSACION A LOS TRABAJADORES BAJO LA R.S 23:1208.1.

Yo he completado este formulario en forma honesta y usando la mayor capacidad de mi conocimiento. Yo entiendo que sí entrego información falsa u omito información pertinente, podría resultar en la pérdida de mis beneficios de la Compensación a los Trabajadores, en caso de recibir una herida/lesión o heridas/lesiones en el lugar de trabajo.

Firma del Empleado: _____ Fecha: _____

Nombre Impreso del Empleado: _____

PARA SER COMPLETADO POR UN REPRESENTANTE DEL EMPLEADOR

ADVERTENCIA AL EMPLEADOR

DE ACUERDO CON La. R.S. 23:1208, DE EL ACTA DE COMPENSACION A LOS TRABAJADORES DE LOUISIANA, DEBE SER ILEGAL PARA UNA PERSONA, CON EL FIN DE OBTENER O ELIMINAR CUALQUIER PAGO DE BENEFICIOS BAJO LAS DISPOSICIONES DE ESTE CAPITULO, YA SEA PARA SI MISMO O PARA CUALQUIER OTRA PERSONA, HACER UNA DECLARACION Y/O ARGUMENTOS FALSOS INTENCIONALMENTE. LAS SANCIONES POR VIOLACIONES COMO ESTAS INCLUYEN PRISION, MULTAS Y/O LA PERDIDA DE LOS BENEFICIOS.

Usted debe certificar lo siguiente:

1. Que yo soy un representante autorizado del empleador designado para obtener y revisar la información proporcionada por el empleado en este cuestionario;

2. Que he proporcionado al empleado con tantas copias como sea necesario de la Página de Explicación y he confirmado el número y etiquetado las páginas de este cuestionario;

3. Que he proporcionado asistencia al empleado (si es requerida) en responder a las preguntas en este cuestionario;

4. Que la información solicitada por esta autorización se realize en un solicitante para el empleo, sólamente después de que una oferta condicional de trabajo haya sido hecha y aceptada, o a un empleado actual; y

5. Que la información obtenida en esta autorización **NO** será usada para discriminar de cualquier manera contra el individuo que es el sujeto de esta autorización en cualquier base, bajo la violación del Acta del año 1990 de los Americanos con Discapacidades, 42 U.S.C. §12101, *et seq*., o cualquier otra ley estatal o federal;

6. Que si es requerido, una fotocopia de este formulario completamente lleno y firmado, será proporcionado al empleado.

Firma del Representate del Empleador:_____ Fecha: _____

Nombre Impreso del Representante del Empleador: _____

Título: _____