POST-HIRE MEDICAL HISTORY QUESTIONNAIRE & THE LOUISIANA SECOND INJURY FUND

The **Post-Hire Medical History Questionnaire** is delivered to employees after they are hired and contains questions regarding the employee's past injuries and medical conditions. The knowledge obtained by the employer from a completed questionnaire serves two purposes. First, as a way of preventing injuries, the employer may be able to accommodate the employee within the job to mitigate any unnecessary risks of re-aggravation to the pre-existing condition. Second, the questionnaire can serve as notice to the employer of the employee's pre-existing medical condition for purposes of ultimate reimbursement from the **Louisiana Second Injury Fund (LSIF)**.

The **LSIF** was created to encourage employers to hire employees who have pre-existing medical conditions. The **LSIF** provides partial reimbursement to an employer/insurer who incurs a claims cost when an employee re-aggravates a known pre-existing medical condition. The **LSIF** is funded by assessing a percentage of the benefits paid by workers' compensation insurers and employers in the state.

Using the **Post-Hire Medical History Questionnaire** as part of your post-hiring process and continual HR procedures is an essential step in gaining access to the **LSIF** backstop. **It is recommended that the questionnaire be completed by all new employees and existing employees.** It is also recommended that the procedure become an annual process within your organization to keep the information current. The LSIF was created to help you lower your claims costs which can in turn **lower the premiums that you have to pay.**

Failure on the part of the employee to answer the Post-Hire Medical Questionnaire truthfully may be grounds of workers' compensation benefits under LA RS 23 § 1208.1.

You may photocopy the **Post-Hire Medical History Questionnaire** form, download it from our website at www.lubawc.com, or call the Claims Department at 1-888-884-5822 for additional forms.

ADA COMPLIANCE

The *Americans with Disabilities Act (ADA)* is federal law regarding discrimination of disabled employees in the workplace. It applies to those businesses that have 15 or more employees. To comply with the ADA, employers are required to follow certain guidelines in obtaining and storing the sensitive information that is requested on the **Post-Hire Medical History Questionnaire**. Although LUBA recommends that you consult your attorney regarding ADA compliance, in general, the following guidelines apply:

1. Following a conditional offer & acceptance of employment, employers may require applicants to complete a **Post-Hire Medical History Questionnaire**, which may include questions about the applicant's pre-existing disabilities in order to meet **LSIF** requirements;

2. The **Post-Hire Medical History Questionnaire** must be used with **all** employees & not selectively utilized;

3. Information obtained must not be used to discriminate against an applicant. **It must be used for legitimate purposes such as pursuing LSIF claims and should be kept separate from personnel records**;

LOUISIANA SECOND INJURY FUND: BENEFITS & REQUIREMENTS

SCHEDULE OF BENEFITS

The **LSIF** has been experiencing solvency problems in the last several years. To remedy this problem, the legislature has altered the program's reimbursement obligations for injuries occurring on or after July 1, 2004 and before June 30, 2007. If these altered terms remedy the **LSIF's** solvency problems, the legislature will allow the program's reimbursement levels to revert to those previously in place.

Once a claim is accepted by the **LSIF**, the benefits paid to LUBA will be credited against the cost of your claim.

For injuries occurring prior to July 1, 2004

- Medical Expenses:
  - $0 - $5,000 — No Reimbursement
  - $5,001 - $10,000 — Reimbursed at 50%
  - Over $10,000 — Reimbursed at 100%
- Indemnity Benefits: Reimbursed at 100% after a deductible of 104 weeks
- Death Benefits: Reimbursed at 100% after a deductible of 175 weeks

For injuries occurring on or after July 1, 2004 and before June 30, 2007

- Medical Expenses:
  - $0 - $25,000 — No Reimbursement
  - Over $25,000 — Reimbursed at 100%
- Indemnity Benefits: Reimbursed at 100% after a deductible of 180 weeks
- Death Benefits: Reimbursed at 100% after a deductible of 130 weeks

REQUIREMENTS

There are four main requirements that must be met in order to receive any type of reimbursement from the **LSIF**:

1. **Disability:** The employee must have a pre-existing medical disability of such seriousness to be a hindrance or obstacle to obtaining employment. This usually involves a previous surgery, amputation, or other physical impairment, but can include non-occupational conditions such as diabetes, hypertension and heart disease, etc.; diseases that would not commonly be associated with any type of employment.

2. **Knowledge:** The employer must have actual knowledge of the pre-existing medical condition prior to the subsequent injury. This "knowledge" can be obtained by written documentation from a representative of the employer with the capacity to hire and fire, which documents they were aware of the disability and how and when this knowledge was obtained. The **Post-Hire Medical History Questionnaire** attempts to fulfill this requirement.

3. **Merger:** There must be some "merger" of the pre-existing disability with the subsequent injury in that the subsequent injury would not have occurred but for the pre-existing disability **or** the disability resulting from the subsequent injury is substantially greater than that which would have resulted had the preexisting permanent partial disability not been present.

4. **Timely Filing:** Any claim for **LSIF** reimbursement must be filed within 52 weeks of the first payment of benefits (either medical or indemnity).

POST-HIRE MEDICAL HISTORY QUESTIONNAIRE

The following questionnaire is a tool to help mitigate workers' compensation claims costs for employers. This form may be utilized to assist in the determination of an employee's job duties, accounting for any previous medical problems. It will also serve as evidence of employer knowledge of an employee's medical condition for purposes of reimbursement from the Louisiana Second Injury Fund, should the employee re-aggravate a previous condition.

The questionnaire is to be completed by employees **after** they are hired. **Do not** use this form as a pre-employment survey as it may, in that context, be considered a violation of the *Americans with Disabilities Act* (ADA).

Instructions: Pages (1) through (6) should be completed by all current employees and all new hires. The forms should be signed by a representative of the employer who has hire/fire authority. The forms should be kept in an employee's medical file, separate from other HR documentation. **Do not** keep this form with an employee's standard HR file. If an employee sustains a work place injury, please submit a copy of this form to:

LUBA Workers' Comp
Attn: Claims Dept.
P.O. Box 98082
Baton Rouge, LA 70898-9082

WARNING ! ! ! !

The Post-Hire Medical History Questionnaire is being furnished to you as a courtesy and the language therein should be considered that of a sample. Because the Post-Hire Medical History Questionnaire is a sample, LUBA Workers' Comp makes no claims, promises or guarantees about the accuracy, completeness, or legal adequacy of its contents. Furthermore, LUBA does not provide any warranties, expressed or implied, with regard to the form. LUBA highly recommends that you consult legal counsel before implementing the Post-Hire Medical History Questionnaire for use in your operations.

POST-HIRE MEDICAL HISTORY QUESTIONNAIRE

WARNING

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

Please check in the appropriate space whether or not you currently have or have previously had any of the following conditions:

Condition	Answer	Condition	Answer
Epilepsy	☐ YES ☐ NO	Headaches	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Head Pain	☐ YES ☐ NO
Heart Disease	☐ YES ☐ NO	Hyperinsulism	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	Muscular Dystrophy	☐ YES ☐ NO
Amputated Foot, Leg, Arm or Hand or Loss of Use Thereof	☐ YES ☐ NO	Arteriosclerosis	☐ YES ☐ NO
Loss of Sight, Partial or Total	☐ YES ☐ NO	Thrombophlebitis	☐ YES ☐ NO
Double Vision or Blurred Sight	☐ YES ☐ NO	Varicose Veins	☐ YES ☐ NO
Poliomyelitis	☐ YES ☐ NO	Heavy Metal Poisoning	☐ YES ☐ NO
Cerebral Palsy	☐ YES ☐ NO	Brain Damage	☐ YES ☐ NO
Multiple Sclerosis	☐ YES ☐ NO	Discectomy	☐ YES ☐ NO
Parkinson's Disease	☐ YES ☐ NO	Spinal Fusion	☐ YES ☐ NO
Stroke	☐ YES ☐ NO	Surgical Removal of Lumbar or Cervical Disc	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO	Cervical Fusion	☐ YES ☐ NO
Silicosis	☐ YES ☐ NO	Knee Pain	☐ YES ☐ NO
Asbestosis	☐ YES ☐ NO	Knee Soreness	☐ YES ☐ NO
Mental Disability	☐ YES ☐ NO	Shooting Pains	☐ YES ☐ NO
Hemophilia	☐ YES ☐ NO	Numbness	☐ YES ☐ NO

EMPLOYEE SIGNATURE: ______________________________ **DATE:** ______________________________

EMPLOYER SIGNATURE: ______________________________ **DATE:** ______________________________

Revised 1/06

WARNING

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

Osteomyelitis	☐ YES ☐ NO	Tingling	☐ YES ☐ NO
Head Injury	☐ YES ☐ NO	Dizziness	☐ YES ☐ NO
Nervous Breakdown, Anxiety or Depression	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO
Ionizing Radiation Injury	☐ YES ☐ NO	Rotator Cuff Injury	☐ YES ☐ NO
Compressed Air Sequelae	☐ YES ☐ NO	Pain and/or Stiffness in Toe(s)	☐ YES ☐ NO
Bronchitis	☐ YES ☐ NO	Sore Neck	☐ YES ☐ NO
Emphysema	☐ YES ☐ NO	Neck Pain	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Neck Ache	☐ YES ☐ NO
Ruptured Disc(s)	☐ YES ☐ NO	Sore Back	☐ YES ☐ NO
Bulging Disc(s)	☐ YES ☐ NO	Back Pain	☐ YES ☐ NO
Tingling Sensation in Arms, Legs, Fingers or Toes	☐ YES ☐ NO	Back Ache	☐ YES ☐ NO
Leg Pain	☐ YES ☐ NO	Difficulty Moving Neck	☐ YES ☐ NO
Leg Soreness	☐ YES ☐ NO	Difficulty Moving Back	☐ YES ☐ NO
Fractured or Broken Bones	☐ YES ☐ NO	Knee Injury	☐ YES ☐ NO
Difficulty Lifting	☐ YES ☐ NO	Loss of Consciousness	☐ YES ☐ NO
Difficulty Stooping	☐ YES ☐ NO	Difficulty Moving Lower Extremities	☐ YES ☐ NO
Difficulty Bending	☐ YES ☐ NO	Difficulty Moving Knees	☐ YES ☐ NO
Shooting Pains Down From Back Through Lower Extremities	☐ YES ☐ NO	Knee Stiffness	☐ YES ☐ NO
Shooting Pains Down From Neck or Upper Back Through Arms	☐ YES ☐ NO	Back Stiffness	☐ YES ☐ NO

EMPLOYEE SIGNATURE: ______________________ **DATE:** ______________________

EMPLOYER SIGNATURE: ______________________ **DATE:** ______________________

Revised 1/06

WARNING

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

Hodgkin's Disease	☐ YES ☐ NO	Neck Stiffness	☐ YES ☐ NO
Mental Retardation	☐ YES ☐ NO	Neck Injury or Neck Symptoms	☐ YES ☐ NO
Carpal Tunnel Syndrome	☐ YES ☐ NO	Back Injury or Back Symptoms	☐ YES ☐ NO
Hypertension	☐ YES ☐ NO	Pain and/or Stiffness in Finger(s)	☐ YES ☐ NO
Pain and/or Stiffness in Hand(s)	☐ YES ☐ NO	Shoulder Pain	☐ YES ☐ NO
Foot Ailment/Pain	☐ YES ☐ NO	Pain and/or Stiffness in Wrist(s)	☐ YES ☐ NO
Arthroscopy	☐ YES ☐ NO	Hearing Loss	☐ YES ☐ NO

If you answered **YES** to any of the conditions, **please explain below** the nature of your injury, condition, or the type of treatment received, the name, address and phone number of the doctor providing the treatment and any impairment or disability that may have been assigned as a result of the injury.

____

____

____

____

____

____

____

____

EMPLOYEE SIGNATURE: ______________________________ **DATE:** ______________________________

EMPLOYER SIGNATURE: ______________________________ **DATE:** ______________________________

Revised 1/06

WARNING

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

Has any doctor ever restricted your activities? ☐ YES ☐ NO

If you answered YES, please list the medical condition, type of restrictions placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.

____

____

Have you ever been assessed any percentage of permanent disability to any part of your body for any reason whatsoever? ☐ YES ☐ NO

If you answered YES, please explain:

____

____

Are you presently under any medical treatment by a doctor, chiropractor, psychiatrist, psychologist or other health care provider? ☐ YES ☐ NO

If you answered YES, please list the medical condition(s) being treated, the name of the doctor(s), field of specialty, address and telephone number.

____

____

Are you presently taking any medication? ☐ YES ☐ NO

If you answered YES, please list the name of the medication, the medical condition being treated, and the name, address and telephone number of the doctor who prescribed the medication.

____

____

EMPLOYEE SIGNATURE: __________________________ **DATE:** __________________________

EMPLOYER SIGNATURE: __________________________ **DATE:** __________________________

Revised 1/06

WARNING

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

Have you ever had surgery to any part of your body? ☐ YES ☐ NO

If you answered YES, please list the part(s) of the body operated on, the type of operation performed, the date of the operation, the name of the hospital, if any, where the operation was performed, and the name, address and phone number of the doctor performing the surgery.

____

____

Have you ever received treatment for your back, neck, knees or lower extremities from a doctor, chiropractor, therapist or other health care provider? ☐ YES ☐ NO

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

____

____

Have you ever had an injury which required you to miss time from work? ☐ YES ☐ NO

If you answered YES, please list the type of injury, the amount of time missed from work, whether the condition was fully resolved or if it left you with any impairment, and whether you returned to work.

____

____

Are you aware of any condition or injury that might impair or limit your ability to work for this company? ☐ YES ☐ NO

If you answered YES, please describe the condition or injury.

____

____

EMPLOYEE SIGNATURE: ____________________ **DATE:** ____________________

EMPLOYER SIGNATURE: ____________________ **DATE:** ____________________

Revised 1/06

WARNING

"PURSUANT TO LSA-RS 23:1208 AND 1208.1 OF THE LOUISIANA WORKERS' COMPENSATION ACT, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS BELOW SHALL RESULT IN (1) A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS OR IMPRISONMENT FOR NOT MORE THAN TWELVE MONTHS, OR BOTH AND (2) A FORFEITURE OF COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION ACT."

I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

EMPLOYEE SIGNATURE: ______________________________ DATE: ______________________________

1208.1 Employer's inquiry into employee's previous injury claims:
Forfeiture of Benefits

Nothing in this Title shall prohibit an employer from inquiring about previous injuries, disabilities, or other medical conditions and the employee shall answer truthfully; failure to answer truthfully shall result in the employee's forfeiture of benefits under this Chapter, provided said failure to answer directly relates to the medical condition for which a claim for benefits is made or affects the employer's ability to receive reimbursement from the second injury fund. This section shall not be enforceable unless the written form on which the inquiries about previous medical conditions are made contains a notice advising the employee that his failure to answer truthfully may result in his forfeiture or workers' compensation benefits under R.S. 23:1208:1. Such notice shall be prominently displayed in bold-faced block lettering of no less than ten point type.

I HAVE REVIEWED THE INFORMATION PROVIDED BY THE ABOVE-SIGNED EMPLOYEE ON THIS POST-HIRE MEDICAL HISTORY QUESTIONNAIRE AND AFFIRM THAT I HAVE KNOWLEDGE OF ANY MEDICAL CONDITIONS DISCLOSED HEREIN BY THE EMPLOYEE.

EMPLOYER SIGNATURE: ______________________________ **DATE:** ______________________________