TO: ALL LCTA WORKERS' COMP MEMBERS

FROM: LCTA WORKERS' COMP
RISK MANAGEMENT RESOURCES, INC.

RE: **MANDATORY REQUIREMENT**
"Post Hire Medical History Questionnaire"

LCTA WORKERS' COMP is requiring all Members to obtain a complete **Post-Hire Medical History Questionnaire (PHMQ)** for each Employee. The completion of a **"Post-Hire Medical History Questionnaire"** is now **MANDATORY** for all Members of LCTA WORKERS' COMP.

Attached is a **Post Hire Medical History Questionnaire** which should be utilized in obtaining a medical history from your employees. In the event of a claim, this form will help in clarifying any pre-existing conditions and assist RMR Claims Adjuster in filing for reimbursement on your behalf from the Louisiana Second Injury Fund.

The enclosed form is provided to all Members of the LCTA WORKERS' COMP. This form is being provided to you as a courtesy as a Member of the Fund and the Fund cannot assume any liability whatsoever in connection therewith.

Please contact the Loss Control Department should you have any questions at 1-800-349-3440.

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 COULD RESULT** IN **(1) A FINE OF UP TO TEN THOUSAND DOLLARS OR IMPRISONMENT UP TO TEN YEARS 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:

Epilepsy	☐YES ☐ NO	Headaches	☐YES ☐ NO
Diabetes	☐YES ☐ NO	Head Pain	☐YES ☐ NO
Heart Disease	☐YES ☐ NO	Hyperinsulism (Low Blood Sugar)	☐YES ☐ NO
Arthritis	☐YES ☐ NO	Muscular Dystrophy	☐YES ☐ NO
Amputated Foot, Leg, Arm or Hand or Loss of Use Thereof	☐YES ☐ NO	Arteriosclerosis (Hardening of the Arteries)	☐YES ☐ NO
Loss of Sight, Partial or Total	☐YES ☐ NO	Thrombophlebitis	☐YES ☐ NO
Double Vision or Blurred Sight	☐YES ☐ NO	Pain and/or Stiffness in Finger(s)	☐YES ☐ NO
Poliomyelitis (Polio)	☐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 (Free Bleeder)	☐YES ☐ NO	Numbness	☐YES ☐ NO

NAME: ________________________________ DATE: ___________________________________

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 COULD RESULT IN (1) A FINE OF UP TO TEN THOUSAND DOLLARS OR IMPRISONMENT UP TO TEN YEARS 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		Condition	
Osteomyelitis (Bone Infection)	☐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 (Bends)	☐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

NAME: ______________________________ DATE: ______________________________

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 COULD RESULT IN (1) A FINE OF UP TO TEN THOUSAND DOLLARS OR IMPRISONMENT UP TO TEN YEARS 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		Condition	
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 (High Blood Pressure)	☐YES ☐ NO	Varicose Veins	☐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.

NAME: ____ DATE:___________________________________

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 COULD RESULT IN (1) A FINE OF UP TO TEN THOUSAND DOLLARS OR IMPRISONMENT UP TO TEN YEARS 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.

____

____

NAME: ______________________________ DATE: ______________________________

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 COULD RESULT IN (1) A FINE OF UP TO TEN THOUSAND DOLLARS OR IMPRISONMENT UP TO TEN YEARS 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.

____

____

NAME: ______________________ DATE: ______________________

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 COULD RESULT IN (1) A FINE OF UP TO TEN THOUSAND DOLLARS OR IMPRISONMENT UP TO TEN YEARS 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.

SIGNATURE: ________________________________ DATE: ___________________________________

COMPANY NAME: ____

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.

EMPLOYER'S REVIEW/CERTIFICATION

COMPANY NAME: _________________________________

I certify that I have supervisory authority including the ability to hire/fire and fire employees on behalf of the company, that I have reviewed the employee's responses on this post-hire questionnaire at the time of completion and that I have verified with the employee that he/she fully understood and completed this form.

BY: ____

TITLE: _______________________________________