

**POST HIRE QUESTIONNAIRE FOR
SECOND INJURY FUND QUALIFICATION**

The purpose of this questionnaire is to preserve the Employer's right to obtain Second Injury Fund reimbursement if you suffer a work-related injury in employment. If the resulting disability is greater due to aggravation of a pre-existing condition, or because the injury combines with the pre-existing condition, the Employer may be able to obtain reimbursement from the Fund of some workers' compensation benefits paid to you. The completed questionnaire will be retained in your confidential medical file. You may update the information at any time.

Name _____
No. _____

Social Security

Address _____

Date of Birth _____

Telephone _____

Have you ever had, or do you now have, any of the following conditions? *Note: this list is derived from Alaska Statute 23.30.205. PLEASE COMPLETE BOTH COLUMNS.*

YES	NO		YES	NO	
___	___	EPILEPSY	___	___	DIABETES
___	___	MUSCULAR DYSTROPHY (any form)	___	___	HYPERINSULINISM
___	___	PARKINSON'S DISEASE	___	___	TUBERCULOSIS
___	___	POLIOMYELITIS residuals	___	___	LOSS OF SIGHT one or two eyes
___	___	CEREBRAL PALSY	___	___	VISION LOSS greater than 75%
___	___	CEREBRAL VASCULAR ACCIDENT(Stroke)	___	___	bilaterally, uncorrected
___	___	MULTIPLE SCLEROSIS	___	___	VARICOSE VEINS
___	___	CHRONIC OSTEOMYELITIS	___	___	THROMBOPHLEBITIS
___	___	RUPTURED (HERNIATED) INTERVETEBRAL	___	___	ARTERIOSCLEROSIS
___	___	DISC (SPINAL DISK OR H.N.P.)	___	___	CARDIAC DISEASE of any kind
___	___	ANKYLOSIS OF JOINTS (Fused joints)	___	___	SILICOSIS
___	___	OSTEOPOROSIS	___	___	COMPRESSED AIR SEQUELAE
___	___	ARTHRITIS of any kind	___	___	HEAVY METAL POISONING
___	___	SPONDYLOLISTHESIS	___	___	IONIZING RADIATION INJURY
___	___	HEMOPHILIA	___	___	AMPUTATION foot, leg, arm,hand

Have you ever had, or do you now have any condition, disease or injury which resulted in 200 weeks or more of inability to work? *The 200 weeks need not be continuous. If your answer is yes, please briefly describe the condition or injury.* _____

Have you ever had a permanent impairment rating, single or combined, of 35% of the whole person or greater? *If your answer is yes, please state the condition or injury(ies) which led to the rating.* _____

READ CAREFULLY, SIGN AND DATE:

I understand that the State is relying on me to be honest in my answers, and that concealment of a qualifying condition may result in the State having to pay more for workers' compensation benefits than it would if I had disclosed a qualifying condition. I have answered the above questions to the best of my knowledge. I understand that this information will be kept in my confidential medical file and will be used for workers' compensation purposes only.

Signed _____ Dated _____