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.

Department_____

Name_____ Social Security No._____

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	____	____	THROMBPHLEBITIS
____	____	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 if I knowingly make a false statement regarding my physical condition, I may not receive Workers' Compensation benefits under AS 23.30, the Alaska Workers' Compensation Act. I understand that this information will be kept in my confidential medical file and will be used for workers' compensation purposes only.

Signed _____ Dated _____

Rev. May 2005