



## **RPS Atlas Workers' Compensation Program 040997**

Gallagher Bassett Louisiana WC Claims Kit for  
Endurance Assurance Corporation Claims

# Table of Contents

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- 
- 01\_**Accident Reporting Instructions**
  - 02\_**Provider and Pharmacy information**
  - 03\_**Provider First Fill card**
  - 04\_**GBGO\_mygbclaim – Spanish Flyer**
  - 04\_**GBGO\_mygbclaim – English Flyer**
  - 05\_**Louisiana State Forms**

## **Accident Reporting Instructions**

**FOR SERIOUS OR LIFE-THREATENING INJURIES, CALL 911 OR TAKE EMPLOYEE TO NEAREST EMERGENCY ROOM IMMEDIATELY**

**Effective 7/1/2025 forward, Gallagher Bassett is the claims administrator for RPS Atlas's workers' compensation Endurance Assurance Corporation claims. Claims should be reported via one of the following methods:**

- 1) **Telephonic reporting:** 833-378-4031
  - 2) **Fax:** 866-668-7780
    - Please use the attached claim reporting form
  - 3) **Email reporting:** [Atlasworkcompclaims@gbtpa.com](mailto:Atlasworkcompclaims@gbtpa.com)
    - Please use the attached claim reporting form
- Report all accidents/injuries immediately. Delays in reporting can significantly increase claim costs.
  - Reporting a claim is NOT an admission that the claim is compensable. GB will investigate all accidents and determine if workers' compensation benefits are due.

### **Helpful information to have on hand when reporting new incidents:**

#### **CLIENT INFORMATION**

- Client Number: Your GB client number is **040997**

#### **INJURED EMPLOYEE INFORMATION**

- Name
- Employee ID number
- Social security number
- Date of Birth
- Address and home phone number
- Personal email address
- Date of hire
- Marital Status
- Number of dependents
- Policy number (if known)
- Policy effective date (if known)

#### **ACCIDENT INFORMATION**

- Date and time of injury
- Location (city and state) of employer location
- Specific description of injury (i.e., employee slipped and fell on wet floor in warehouse)
- Any unsafe behavior that contributed to the accident
- Name and address of injured employee's physician or facility, if treatment already obtained for the injury

## **Gallagher Bassett Customer Support**

GB Toll Free 833-707-6338

## **Obtaining medical care for your injured employee:**

**FOR SERIOUS OR LIFE-THREATENING INJURIES, CALL 911 OR TAKE EMPLOYEE TO NEAREST EMERGENCY ROOM IMMEDIATELY**

## **To locate in-network providers near your locations at:**

[www.talispaint.com/cvty/gbppo](http://www.talispaint.com/cvty/gbppo)

Through this site you can choose from several options to request the providers. Searches can be done by address, name, region, as well as a quick search which is a preformatted search using a limited number of specialties for providers who provide initial treatment of WC injuries only. Outcome Based Network (OBN) providers are identified by a rainbow circle design before their name. The site also provides you with the capability of creating your own preformatted worksite posters. There is also a selection to look up state rules which gives you a brief description of the state rules that apply to your direction of medical care for each state.

## **GB Care Pharmacy Benefit Management Program**

**First Fill Program** – this program allows the injured employee to obtain their first fill of medication with no out-of-pocket expense to the employee. When filling a prescription, injured workers simply present the First Fill information to the pharmacy. Once the pharmacy verifies eligibility, injured employees are enrolled.

With over 68,000 contracted pharmacies, including all major pharmacy chains, our unique program design enables injured workers to receive prescriptions without incurring out of pocket expenses and ensures appropriate medications are dispensed during each stage of recovery. The injured employee can also call 1.844.276-2515 to find participating pharmacies.

### **Benefits of the program include:**

- No out-of-pocket expense for injured workers. Injured employees can fill their prescriptions on demand (up to 30-day supply of medical) simply by presenting their myMatrixx information to the pharmacy.
- Home Delivery Programs – for qualified injured employees, myMatrixx offers home delivery of medications. Depending upon past use and type of injury, the system automatically identifies those who might benefit, providing added convenience and promoting their recovery.

# Occupational Injury Temporary Prescription ID Card



## To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 844-276-2515.

## Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 844-276-2515.

## To the Pharmacist:

myMatrixx, an Express Scripts company administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of \$500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 844-276-2515.

## Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

**myMatrixx**, an Express Scripts Company

**ID#:** \_\_\_\_\_

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

**Date of Injury:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM/DD/YYYY

**Group #:** NZEA

**Employee Date of Birth:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Thank you** for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

*Please see other side for a list of participating retail network pharmacies.*

## To the Supervisor:

Please fill in the information requested for the injured worker.

## Employee Information

First M Last

Street Address or PO Box

City State ZIP

## Employer Name

RPS Atlas Workers Compensation Program

## Participating Retail Network Pharmacies

A & P	Drug Emporium	Medic Discount	Scolari's
Acme Pharmacy	Drug Fair	Medicap	Sedano
Albertson's	Drug Town	Medistat	Shaw's
Albertson's/Acme	Drug World	Meijer	Shop 'N Save
Albertson's/Osco	Eckerd	Minyard	Shopko
Albertson's/Sav-On	Econofoods	NCS HealthCare	ShopRite
Amerisource Bergen	EPIC Pharmacy	Neighborcare	Snyder
Anchor Pharmacies	Network	Network	Stop & Shop
Arrow	FamilyMeds	Pharmaceuticals	Sun Mart
Aurora	Farm Fresh	Northeast Pharmacy	Super Fresh
Bartell Drugs	Farmer Jack	Services	Super Rx
Bigg's	Food City	Osco	Target
Bi-Lo	Food Lion	P & C Food Markets	Texas Oncology Svcs
Bi-Mart	Gemmel	Pamida	The Pharm
BJ's Wholesale Club	Giant	Park Nicollet	Thrifty White
Brooks	Giant Eagle	Pathmark	Times
Brookshire Brothers	Giant Foods	Pavilions	Tom Thumb
Brookshire Grocery	Hannaford	Price Chopper	Tops
Bruno	H-E-B	Publix	Ukrop's
Carrs	Hi-School Pharmacy	Quality Markets	United Drugs
Cash Wise	Hy-Vee	Raley's	United Supermarkets
Coborn's	Jewel/Osco	Randalls	Vons
Costco	Kash n Karry	Rite Aid	Waldbaums
Cub	Keltsch	Rosauers	Walgreens
CVS	Kerr	Rx Express	Wal-Mart
D&W	Kmart	RXD	Wegmans
Dahl's	Knight Drugs	Safeway	Weis
Dierbergs	LeaderNet (PSAO)	Sam's Club	Winn Dixie
Discount Drugmart	Longs Drug Store	Sav-On	
Doc's Drugs	Major Value	Save Mart	
Dominicks	Marsh Drugs	Schnucks	

### **GBGO Mobile App**

- Your injured employee will receive an acknowledgement letter giving them their claim number and resolution manager contact information, along with information on accessing GBGO, our mobile app:



## GBGO® — Taking claims management mobile

In a world that keeps moving, GB delivers the best possible claim experience to both clients and injured workers. Through GBGO, a mobile suite that provides faster and better communication, GB keeps all parties engaged throughout the claims process and improves overall satisfaction with the claim experience.

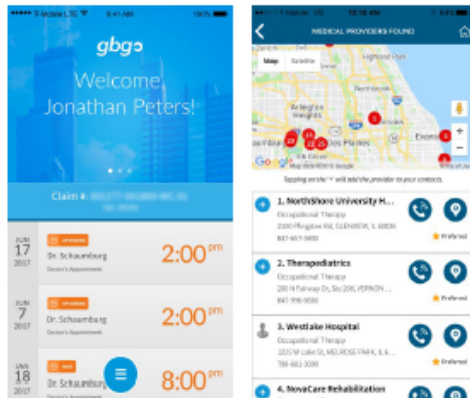
The GBGO MYGBCLAIM App lets injured workers manage their claim anytime, anywhere from their Apple or Android smartphone. The app is secure, easy to use and reliable. The following is a list of features currently supported.

### Existing Features

- **GBGO SMART bar** – Access personalized messages, notifications, reminders, FAQs, and more
- **Payments** – View benefit payments history and get notifications related to payment updates, enroll in Direct Deposit
- **Doctor Appointments** – Input your next doctor appointment and let the app track it and remind you.
- **Medical Cards** – Access digital versions of the Medical Card and the Pharmacy card (Rx Card) with 'one click'.
- **Connect with your RM** – Phone or email your GB RM (Resolution Manager) with 'one click'.
- **Report Release to Return to Work** and request your RM (Resolution Manager) to update your contact information from the app.
- **FAQs** – Access answers to frequently asked questions 24 x 7
- **App feedback** – Tell us what you think
- **Experience the app in Spanish**
- **Pre-Claim Access** – Access your Medical Awareness Card (MAC) after your call with the PC365 Nurse
- **Claim Contacts** – Add, Manage and Access Claim Contacts from one screen – RM, Providers and Pharmacies. Call or get directions to the provider location with one click
- **Provider and Pharmacy Search** – Search for a Preferred medical provider or pharmacy near you
- **Attachments** – Send attachments (Doctor Notes, Mileage Reimbursement requests etc.) to your RM directly from the App

### Upcoming New Features

- **Messaging capabilities**



### How to:

- Download the app from the Apple or Google app store by following the links below or search for GBGO mygbclaim
- Click on "Register" link at the top of the home screen. Follow the instructions and create an account to start accessing information about your claim
- In case of questions do not hesitate to email or call-us using the links at the bottom of the home page

For Apple devices:



For Android Devices:



**WHEN PEOPLE ARE EMPOWERED THEY CAN ACHIEVE AMAZING THINGS. THAT'S THE POWER OF GBGO.**



## GBGO®— Llevando la administración móvil de reclamos

En un mundo que sigue en movimiento, GB ofrece la mejor experiencia de reclamo posible tanto para clientes como para trabajadores lesionados. A través de GBGO®, una suite móvil que brinda una comunicación más rápida y mejor, GB mantiene a todas las partes involucradas a lo largo del proceso de reclamos y mejora en general la satisfacción con la experiencia del reclamo.

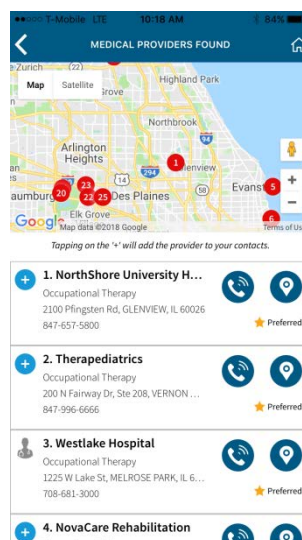
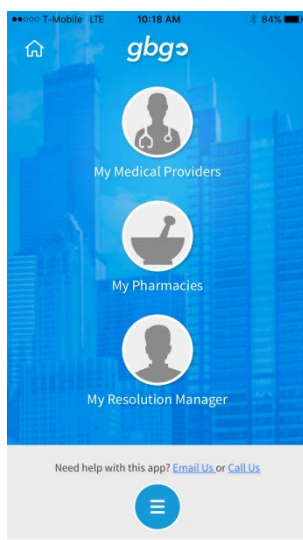
La aplicación GBGO MYGBCLAIM permite a los trabajadores lesionados gestionar su reclamo en cualquier momento y en cualquier lugar desde su teléfono inteligente Apple o Android. La aplicación es segura, fácil de usar y confiable. La siguiente es una lista de las funciones actualmente soportadas.

### Funciones existentes

- GBGO® SMART bar - Acceder a mensajes personalizados, notificaciones, recordatorios, preguntas frecuentes y más.
- Pagos - Ver el historial de pago de prestaciones y recibir notificaciones relacionadas con las actualizaciones de pago.
- Citas Médicas - Ingrese su próxima cita con el médico y permita que la aplicación la rastree y le envíe un recordatorio.
- Tarjetas médicas - Acceda a las versiones digitales de la Tarjeta médica y la Tarjeta de la farmacia (Tarjeta Rx por sus siglas en Inglés) con 'un clic'.
- Conéctese con su Gerente de Resolución (RM por sus siglas en Inglés) - Por teléfono o envíe un correo electrónico a su GB RM con 'un clic'.
- Reporte la Alta de Regreso a Labores y solicite a su Gerente de Resolución (RM por sus siglas en Inglés) que actualice su información de contacto desde la aplicación.
- Preguntas frecuentes - Acceda a las respuestas a las preguntas frecuentes 24 x 7.
- Comentarios de la aplicación - Díganos lo que piensa.
- Experimente la aplicación en español

### Nuevas funciones (serán liberadas el 14 de mayo)

- Acceso previo al reclamo - Acceda a su tarjeta de reconocimiento médico (MAC, por sus siglas en inglés) después de su llamada con la enfermera PC365.
- Contactos del Reclamo - Agregue, administre y acceda a los contactos del reclamo desde una pantalla - Gerente de Resolución, Proveedores y Farmacias. Llame u obtenga indicaciones sobre la ubicación del proveedor con un clic.
- Búsqueda de proveedores y farmacias - Busque un proveedor médico o farmacia preferida cerca de usted.
- Archivos Adjuntos - Envíe archivos adjuntos (notas del médico, solicitudes de reembolso de millas, etc.) a su Gerente de Resolución directamente desde la aplicación.



### Cómo:

- Descargar la aplicación desde App Store o Google Play siguiendo los enlaces que se muestran en la parte inferior o busque GBGO® mygbclaim.
- Haga clic en el enlace "Registrarse" en la parte superior de la pantalla de inicio. Siga las instrucciones y cree una cuenta para comenzar a acceder a la información sobre su reclamo
- En caso de preguntas, no dude en enviarnos un correo electrónico o llamarnos usando los enlaces en la parte inferior de la página de inicio

Para dispositivos Apple:



Para dispositivos Android:



# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE			
				JURISDICTION		JURISDICTION CLAIM NUMBER					
				INSURED REPORT NUMBER							
INDUSTRY CODE				EMPLOYER FEIN				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #	
								PHONE #			
<b>CARRIER/CLAIMS ADMINISTRATOR</b>											
CARRIER (NAME, ADDRESS, & PHONE #)				POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)					
				TO							
CARRIER FEIN				POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN			
SELF INSURANCE											
				AGENT NAME & CODE NUMBER							
<b>EMPLOYEE/WAGE</b>											
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED		STATE OF HIRE	
ADDRESS (INCL ZIP)				SEX		MARITAL STATUS		OCCUPATION/JOB TITLE			
				<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS			
PHONE				# OF DEPENDENTS				NCCI CLASS CODE			
RATE PER:		<input type="checkbox"/> DAY	<input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH	<input type="checkbox"/> OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OCCURRENCE/TREATMENT</b>											
TIME EMPLOYEE BEGAN WORK		<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE		DATE EMPLOYER NOTIFIED	
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE			
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL										CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT			
								0 NO MEDICAL TREATMENT			
								1 MINOR: BY EMPLOYER			
								2 MINOR CLINIC/HOSP			
								3 EMERGENCY CARE			
								4 HOSPITALIZED > 24 HOURS			
				5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED							
<b>OTHER</b>											
WITNESSES (NAME & PHONE #)											
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER			

## EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

### DATES:

Enter all dates in MM/DD/YY format.

### INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

### CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

### CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

### AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

### OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

### EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

### DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

### CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

### TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

### PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

### DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg.

Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

## EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

**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.<sup>1</sup> 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: ( \_\_\_\_ ) \_\_\_\_\_

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<sup>1</sup> 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
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Silicosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Parkinson's	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> Brain Damage	<input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input type="checkbox"/> Asbestosis	<input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> Double Vision	<input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> 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: \_\_\_\_\_

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: \_\_\_\_\_