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**Louisiana Department of Labor
Office of Workers' Compensation
P.O. Box 04040
Baton Rouge, LA 70804-9040**

KEY STEPS IN WORKERS' COMPENSATION FOR INJURED WORKERS

1. If you are hurt at work or become ill because of something you believe to be work related:
 - Immediately report your injury or illness to your supervisor. To be eligible for benefits, you must report the injury within 30 days.
 - Seek first aid and medical attention.
 - Continue to keep your employer informed of your condition and any charges.
2. Your employer will report the injury or illness to their insurance company (or internal claims office if self-insured) and to the Office of Workers' Compensation Administration (OWCA).
3. You will be able to select a doctor of your choice. However, your employer may arrange an examination by another doctor, which you must attend. Your medical costs will be paid.
4. If you miss more than seven days of work and your claim is deemed compensable, you may be entitled to benefits, or you may receive compensation for a portion of your lost wages. Workers' compensation insurance also provides benefits to eligible dependents of workers who die as a result of a work-related incident.
5. If your injury or illness is compensable:
 - Benefits will be paid beginning on the eighth day after the injury. You should receive your first benefit check within 14 days after you notify your employer of the injury.
6. If you miss work for more than 42 days, you will then receive compensation for the first seven days following the injury date. Any additional compensation for permanent disability, such as an amputated limb, will be determined after you return to work or at the end of the healing period.
7. Weekly Compensation Benefits:
 - If you have received weekly compensation benefits, you have one year from the date of your last payment to file a formal claim with the OWCA.

- If you have not received any benefit payments, you have one year from the date of your injury or illness to file a formal claim.
8. Medical Benefits:
- If you have received medical benefits, you have three years from the date of the last payment to file a claim for medical benefits.
 - If you have not received any medical benefits, you have one year from the date of your injury or illness to file a claim.
9. Educational Opportunities for a Worker's Dependents:
- Kids' Chance is a scholarship program that provides scholarships to dependants age 16 to 25 for post secondary education of workers suffering a total or permanent disability or death that is compensable under a state or federal workers' compensation act or law. For information on Kids' Chance contact the Louisiana Bar Foundation.
10. BEFORE FILING YOUR CLAIM, KEEP IN MIND THAT:
- Delays in reporting your injury or illness will not only affect your health but also your entitlement to compensation benefits.
 - The law covers both mental and physical injury.
 - The event causing your injury or illness must arise out of and be within the course and scope of your employment.
 - Any fraudulent action taken by an employer, employee or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation will subject such a person to criminal and/or civil penalties.

If you have any questions, please call the Office of Workers' Compensation Administration at (225) 342-7561

EMPLOYEE CERTIFICATE OF COMPLIANCE

You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt. Your workers' compensation benefits may be suspended if you do not timely submit this Certification. You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

It is unlawful for you to work and receive workers' compensation disability benefits, except for supplemental earnings benefits. Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earnings to your insurer quarterly.

It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits. Permanent partial disability benefits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to \$10,000, imprisoned up to 90 days, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined, imprisoned, or both, as follows:

<u>Unlawful Benefits Paid or Claimed</u>	<u>Fine</u>	<u>Imprisonment</u>
\$10,000 or more	up to \$10,000	up to 10 years, with or without hard labor
\$2,500 or more but less than \$10,000	up to \$ 5,000	up to 5 years, with or without hard labor
less than \$2,500	up to \$500	up to 6 months

In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000 and may forfeit your right to receive workers' compensation benefits.

EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and that I understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

_____	_____	_____	_____
Print Name	Signature	Social Security Number	Date
_____	_____	_____	()
Address	City	State / Zip	Phone Number

Note: Only one copy is required per case from the employee.
Please mail this form to your employer or your employer's insurer.

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of \$500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized selfinsured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to \$10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than \$500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to \$10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000.

EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)

Signature

Date

Company Name

Company Address

()

Phone Number

Insurance Policy Number

Employee Name

Employee Social Security Number

NOTICE TO ALL EMPLOYEES

We are committed to providing Workers' Compensation benefits to all employees who suffer and employment-related disability in accordance with Louisiana law.

If this disability or inability to return to work is made worse because of a pre-existing disability, or because the employee suffered an earlier accident, illness, disease, physical or mental disability, or condition which we knew about in advance, a reimbursement for some of the benefits paid under the Second Injury Fund may be applicable.

In order to apply for Second Injury Fund Relief, we request that every employee answer the attached questionnaire.

This information will be kept CONFIDENTIAL by us. We WILL NOT discriminate against hiring or continuing the employment of any disabled person. This information may assist us in determining your ability to perform essential functions of your employment and what reasonable accommodations we may make to meet the needs of our employees.

The information may also be assessed in case of medical emergency.

FAILURES TO ANSWER THE ATTACHED QUESTIONNAIRE TRUTHFULLY AND COMPLETELY MAY AFFECT YOUR EMPLOYMENT STATUS, UP TO AND INCLUDING, TERMINATION.

WARNING: PURSUANT TO LSA-R.S. 23: 1208.1, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE ATTACHED QUESTIONS MAY RESULT IN DENIAL OF ANY RIGHT I OR MY DEPENDENTS MAY HAVE TO WORKER'S COMPENSATION BENEFITS, INCLUDING MEDICAL TREATMENT AND EXPENSES.

**EMPLOYEE MEDICAL HISTORY QUESTIONNAIRE
FOR SECOND INJURY FUND PURPOSES UNDER
LSA-R.S. 23: 1371 ET et seq.**

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

	YES	NO
Epilepsy	_____	_____
Diabetes	_____	_____
Heart Disease	_____	_____
Arthritis	_____	_____
Amputated foot, leg, arm, or hand or loss of use thereof	_____	_____
Loss of sight, partial or total	_____	_____
Double vision or blurred sight	_____	_____
Poliomyelitis	_____	_____
Cerebral Palsy	_____	_____
Multiple Sclerosis	_____	_____
Parkinson's Disease	_____	_____
Stroke	_____	_____
Tuberculosis	_____	_____
Silicosis	_____	_____
Asbestosis	_____	_____
Mental Disability	_____	_____
Hemophilia	_____	_____
Osteomyelitis	_____	_____
Head Injury	_____	_____
Ankylosis of Joints	_____	_____
Hyperinsulism	_____	_____
Muscular Dystrophy	_____	_____

	YES	NO
Arteriosclerosis	_____	_____
Thrombophlebitis	_____	_____
Varicose Veins	_____	_____
Heavy Metal Poisoning	_____	_____
Brain Damage	_____	_____
Spinal Fusion or surgical removal of an intervertebral disc	_____	_____
Dizziness	_____	_____
Nervous Breakdown	_____	_____
Ionizing Radiation Injury	_____	_____
Compressed Air Sequelae	_____	_____
Bronchitis	_____	_____
Emphysema	_____	_____
Asthma	_____	_____
Ruptured Intervertebral disc	_____	_____
Hodgkin's Disease	_____	_____
Mental Retardation	_____	_____
Carpal Tunnel Syndrome	_____	_____
Hypertension	_____	_____
High Blood Pressure	_____	_____
Rotator Cuff Injury	_____	_____
Knee Injury	_____	_____
Neck Injury	_____	_____
Back Injury	_____	_____

If you have answered "yes" above, for each affirmative answer please provide the following information about any doctor, chiropractor, psychiatrist, psychologist or therapist who has treated you for the condition(s): (Please use the reverse of this form if necessary.)

Condition _____
Dr. Name _____
Address _____

Phone # _____
Diagnosis _____
Dates of
Treatment _____

Condition _____
Dr. Name _____
Address _____

Phone # _____
Diagnosis _____
Dates of
Treatment _____

Condition _____
Dr. Name _____
Address _____

Phone # _____
Diagnosis _____
Dates of
Treatment _____

Condition _____
Dr. Name _____
Address _____

Phone # _____
Diagnosis _____
Dates of
Treatment _____

Have you ever had an injury, disability or illness that required you to miss time from work?

YES _____ NO _____

If your answer to 3 above is "yes", please provide the following information concerning the previous condition:

Employer _____

Injury, illness or disability _____

Time Missed from work _____

Name of Doctor who treated you _____

Did you receive worker's compensation benefits? YES _____ NO _____

Has conditions fully healed? YES _____ NO _____

Any residual impairment or restrictions? YES _____ NO _____

Did you return to work? YES _____ NO _____

Have you ever been turned down for any employment, medical, health or life insurance or military services because of your health or mental condition? YES _____ NO _____

If "yes", please explain: _____

When did you last see a doctor? _____

Name and address of doctor who treated you. _____

Condition treated _____

Name and address of your family doctor

Has a doctor ever restricted your activities? _____

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

Are you presently taking any medication? _____

If so, please list the name of the medication, the medical condition being treated, and the name, address and phone number of the doctor who prescribed the medication.

Have you ever had surgery to any part of your body?

If so, please list the part of your body operated on, what 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.

Are you allergic to any medications? _____

If so, please list. _____

Please list all known allergies. _____

Please list name and telephone number of person to contact in case of an emergency.

WARNING: PURSUANT TO LSA-R.S. 23: 1208.1, I UNDERSTAND THAT THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE ATTACHED QUESTIONS MAY RESULT IN DENIAL OF ANY RIGHT I OR MY DEPENDENTS MAY HAVE TO WORKER'S COMPENSATION BENEFITS, INCLUDING MEDICAL TREATMENT AND EXPENSES.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE.

Date

EMPLOYEE SIGNATURE