Revised February 26 2016

Adult Intern and Volunteer Application

Dear Community Friend:

Thank you for your interest in volunteering and/or an unpaid internship position at Slidell Memorial Hospital (SMH). Both can be quite rewarding to you personally and, of course, is a great help to the hospital, patients, visitors, staff and community.

The goal of the Volunteer Department is to help SMH grow from a good hospital to a great hospital! If you are willing to help us reach this goal, I invite you to join our team!

The following information will help guide you through the application process:

- Application Packet which includes the following should be filled out and returned:
  - Application
  - Agreement
  - Authorization and Consent for Release of Information (Background Check Form)
  - Health Assessment
  - Interest and Skills Form
- Once you have been accepted into the program, you will be scheduled for orientation which is held twice a month. Attendance is required by all volunteers and interns. You will be notified of date and time. During orientation:
  - A TB Health Screening test will be administered. It will have to be checked by a registered nurse 2-3 days later. Full instructions will be provided at orientation.
  - A Color Blindness test will be administered.
  - Instructions for taking the drug screen test will be provided.
- Your criminal background check will be processed shortly after orientation.
- Once your criminal background check is completed, you will be contacted to schedule your first day!

1001 Gause Boulevard
Slidell, Louisiana 70458-2987
(985) 280-2200
www.slidellmemorial.org

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Additional Information:

- Probationary Period – All volunteers and interns are placed on a 60 day probationary period. During this time, you will be mentored by a "Lead Volunteer" and trained at one of the Welcome/Information areas. This will allow you to learn about all areas of the hospital, meet staff, volunteers and other interns and most importantly learn about the many opportunities available to you after your probationary period.

- Dress Code – All volunteers and interns are to dress in "business casual" attire. This mean slacks or pants, dresses or skirts and comfortable walking shoes. Please do not wear jeans or shorts. You will be issued a jacket or polo shirt—depending on your assignment.

- Parking – Adult volunteers and interns are authorized to park in the parking garage, but if physically able, we ask that you park behind Founders on Robert Rd., and take the SMH shuttle. Additional information will be given during orientation.

- Smoking Policy – Because we care, SMH is tobacco-free. To protect and promote good health, smoking and the use of other tobacco products is not permitted anywhere on hospital property, both inside and outside. This policy applies to everyone including staff, volunteers, interns, patients, visitors, vendors and contractors.

Your interest in volunteering or an unpaid intern position at Slidell Memorial Hospital is greatly appreciated. Please feel free to contact me at 985-280-8531 if you have any questions. I look forward to hearing from you soon.

Sincerely,

Laurie Manley

Laurie Manley
Volunteer Coordinator

Enclosures

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VOLUNTEER and INTERN APPLICATION

DATE:_____ T-shirt/Polo size: _____

NAME:_____DATE OF BIRTH: _____
Last First Middle

HOME ADDRESS: _____
Street City/State ZIP

PHONE:_____(h)_____(c)

E-MAIL ADDRESS: _____

Volunteer/Intern Categories (Check all that apply):

_____Year Round Volunteer or Intern
_____Summer Intern Only
_____Adult Volunteer or Intern (over 18+)
_____College Student: College Name:_____Freshman Sophomore Junior Senior

HOW MANY TOTAL DAYS PER WEEK ARE YOU AVAILABLE? : _____

DAYS AND TIMES AVAILABLE TO VOLUNTEER/Intern (check all that apply):

Monday:	___6am-11am	___8am – 1pm	____noon - 5pm	____4 - 8pm	___8pm - midnight
Tuesday:	___6am-11am	___8am – 1pm	____noon - 5pm	____4 - 8pm	___8pm - midnight
Wednesday:	___6am-11am	___8am – 1pm	____noon - 5pm	____4 - 8pm	___8pm - midnight
Thursday:	___6am-11am	___8am – 1pm	____noon - 5pm	____4 - 8pm	___8pm - midnight
Friday:	___6am-11am	___8am – 1pm	____noon - 5pm	____4 - 8pm	___8pm - midnight
Saturday:	___6am-11am	___8am – 1pm	____noon - 5pm	____4 - 8pm	___8pm - midnight
Sunday:	___6am-11am	___8am – 1pm	____noon - 5pm	____4 - 8pm	___8pm - midnight

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VOLUNTEER and INTERN OPPORTUNITIES

"Angels in the ER" – Assists ER staff as needed. Example of responsibilities include visiting patients, transporting patients, providing information to family members, stocking supplies and helping with initial admission process.

Cancer Center Concierge– Greet visitors/patients, escort patients to their appointments, provide basic information and answer phone calls.

Care Partners – Assigned to a nursing floor to answer call lights, round on patients, restock supplies, transport patients, etc.

Clerical Support – Assigned to an SMH department such as Volunteer Services, Case Management, Accounting, Business Development, SMH Imaging, Marketing, Physician Network, etc. to provide clerical support.

Gift Shop – This is one of the most exciting volunteer or intern assignments at SMH. Not only do they help patients, visitors and staff pick-out gifts, but they help with marketing, merchandising and product selection.

Information Desk Ambassadors – Assigned to one of two information desks to provide information to visitors and patients and walk them to their destinations. This position requires computer skills, and willingness to learn many aspects of the Hospital operations. This assignment is never boring. Information Desk Ambassadors are also responsible for stocking coffee supplies in waiting rooms, delivering newspapers, cards and e-mails throughout the Hospital, sorting incoming SMH mail and assembling packets/mailers as needed.

Patient Comfort Rounds – Visits all patients with "comfort cart" distributing magazines, books, puzzles, pens, bibles, etc. Volunteers or interns in this position must be outgoing, compassionate and have good communication skills.

Receptionist – Assigned to a Department or Doctor office to greet patients and visitors, assist staff process patient orders, answer phones, escort patients and visitors as needed.

Special Event Volunteers/Interns – These volunteers or interns do not keep a "regular" schedule. A Special Event list is distributed monthly, and they pick the events they would like to volunteer for. This includes: health fairs, educational seminars, fundraising activities, etc.

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Surgical Waiting Room – Monitors surgical waiting room, and provides information to family members. This position has a lotof contact with Doctors and Nurses so good communication skills are necessary.

Joint Commission Team – Rounding on different areas of the hospital weekly, evaluating the hospital for environmental of care problems. Additional training will be provided.

Wheelchair Escorts – Assigned to registration and escorts patients to their appointments.

Nursery Support – Answering call lights, rocking babies, etc.

Chaplain – Separate application required. Call 985-280-8531.

Clergy – Separate application required. Call 985-280-8531.

Work from Home Volunteers – This could include making hats, scarfs or lap blankets for distribution to patients, clerical assistance or other jobs as assigned.

Requested Area/Department to volunteer or intern with once you complete your initial 60 day training:

Volunteer/Intern Opportunities			SMH Locations
□ "Angels in the ER"	□ Gift Shop	□ Receptionists	□ Cancer Center
□ Work from Home Volunteer	□ Information Desk Ambassadors	□ Special Events	□ Main Campus
□ Cancer Center Concierge	□ Patient Comfort Rounds	□ Surgical Waiting Room	□ SMH Imaging
□ Care Partners	□ Delivering Supplies to Departments	□ Wheelchair Escorts	□ Out Patient Rehab
□ Clerical Support	□ Pharmacy Support	□ Nursery Support	□ Parenting Center
□ Joint Commission Team	□ Project Management	□ Labor & Delivery	□ Physician Offices
□ Assistant in the Volunteer/Intern Office	□ Runner	□ Other: _____	□ Community Outreach

While our goal is to place you in the volunteer or intern position you request, we cannot guarantee a specific Department or assignment.

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PRIOR VOLUNTEER OR INTERN SERVICE (Where else have you volunteered or interned?):

AGENCY	POSITION	DUTIES

EMPLOYMENT HISTORY: *Please attach a resume if you have one available.*

EMPLOYER	DATES WORKED	DUTIES

Are you retired? □ Yes □ No **If yes, from where?** _____

Were you ever employed by Slidell Memorial Hospital? □ Yes □ No

If yes, please indicate dates employee dates:_____to _____

Are any of your relatives currently employed by Slidell Memorial Hospital?

□ Yes Relatives' Name/Relationship:_____

□ No

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Notice of Substance Detection Policy

The purpose of the Substance Detection Program is to promote optimum safety and well-being of volunteers, interns, employees, patients, and visitors. SMH is committed to providing a safe, productive, healthy, and wholesome environment. We are committed to taking reasonable and necessary steps to provide our hospital community with an environment that is free from the adverse effects of substance abuse, through creating and maintaining a drug-free workplace.

Are you willing to undergo a drug screen test (at our expense) prior to volunteering or interning for SMH?

□ Yes □ No

BACKGROUND CHECK:

We consider the safety and security of our patients, visitors and employees to be of the utmost importance. Applicants must complete an Authorization and Consent for Release of Information form to be screened at our cost for criminal background offenses by state and/or federal agencies. The existence of a criminal record does not constitute an automatic bar from volunteering or interning, but will be considered in relation to your assignment and position requirements.

Have you ever been convicted of a felony or misdemeanor offense? □ Yes □ No

Are there any pending charges on your criminal background report? □ Yes □ No

Have you ever been sanctioned for Medicare fraud? □ Yes □ No

REFERENCES:

NAME	RELATIONSHIP	PHONE NUMBER

Revised February 26 2016

IN CASE OF EMERENCY CONTACT:

_____

Name Home Address ZIP

RELATIONSHIP:_____E-mail: _____

Phone:_____(h)_____(c)

WHY DO YOU WANT TO VOLUNTEER OR INTERN AT SLIDELL MEMORIAL HOSPITAL?

_____

_____

_____

_____

_____

_____

I certify that the statements made in this application are true and correct. I authorize Slidell Memorial Hospital and its agent acting on its behalf to investigate all statements contained in this application. I understand that this information may be disclosed to any party with legal and proper interest and I release Slidell Memorial Hospital from any liability whatsoever for supplying such information. **I understand that I will not be paid for my services as this is strictly volunteer work.** I have read and understand the above statements.

SIGNATURE OF APPLICANT:_____DATE: _____

Please return application package to:

Slidell Memorial Hospital
Attention: Volunteer Services
1001 Gause Blvd.
Slidell, LA 70458

1001 Gause Boulevard
Slidell, Louisiana 70458-2987
(985) 280-2200
www.slidellmemorial.org

Revised August 2014
Revised February 26 2016

Department: Volunteer Services

PLEASE READ CAREFULLY

APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

We truly welcome your application to volunteer or intern with, **SLIDELL MEMORIAL HOSPITAL,** (hereinafter referred as "Company"). We're proud that our success is the result of the quality and caliber of our volunteers. You are applying for a position whose acceptance will place you in a category of recognized Professionals. In pursuit of that excellence we require, as a condition of placement, and/or continued placement, that all applicants consent to and authorize a pre-volunteer verification of the background information submitted on their application or resume.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of volunteering is true and complete to the best of my knowledge. I understand that if I am accepted as a volunteer any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that this company may now, or at any time while you are a volunteer, administer a personality profile, conduct a verification of your education, previous employment/work history, credit history, contact personal references, require that you provide a urine specimen to be tested for the presence of drugs or alcohol, motor vehicle records, worker's compensation from the Department of Labor and/or the Worker's Compensation Commission, and to receive any criminal history record information pertaining to me which may be in the files of any Federal, State, or Local criminal justice agency in any State and/or other information as deemed necessary to fulfill the job requirements.

In conformance with the Americans Disabilities Act, I acknowledge by my **signature**_____that I have been offered a volunteer position, contingent upon a satisfactory background investigation, and therefore, worker's compensation information obtained from the Department of Labor and/or the Worker's Compensation Commission is hereby authorized. If blank, the obtaining of worker's compensation information is not authorized. The results of this verification process will be used to determine eligibility under this Company's employment policies.

I authorize Employment Research Services, (hereinafter referred as "ERS"), and any of its agents/designated by Company Personnel, to disclose orally and in writing the results of this verification process and/or interview to the designated authorized representatives of this Company.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and Agencies to provide ERS and Slidell Memorial Hospital with all information that may be requested, and I hereby release all of the persons and Agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge the Company, our agent, ERS, and their associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if volunteering was denied based on information obtained by SMH, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report.

Volunteer/Intern: Please Print

_____,_____ **SS#:** _____
Last (Maiden) First M.I. U.S. Citizen: Yes_____No_____

Address: _____

_____ **Date of Birth:** _____

Telephone # Home_____**Cell**_____**Alternate**_____

Excluding current residence, list the last two City, State and ZIP codes that you have lived in:

_____

_____

Signature:_____ **Date:** _____
Client # : 402-H25

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CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

IMPORTANT:Please read all information below. If you have any questions regarding this agreement, please ask them of the Volunteer Coordinator or the Director of Human Resources before signing. A copy of this agreement will be provided to you.

ACKNOWLEDGMENT

I recognize and acknowledge the following:

- The services Slidell Memorial Hospital ("SMH") performs for its patients/providers are confidential;
- To enable SMH to render those services, its providers/patients furnish to SMH confidential information concerning their affairs;
- The goodwill of SMH depends, among other things, upon keeping such services and information confidential;
- Because of my duties, I may come into possession of information concerning the services performed by SMH for its patients/providers even though I do not take any direct part in or furnish the services performed for those patients/providers;
- Disclosure of any such information by me may cause irreparable injury to SMH and the owner of the information; SMH or the owner of the information may seek legal remedies against me;
- Computer information belonging to SMH, its patients, providers or vendors is confidential; and disclosure of such information, revealing passwords, PIN numbers, etc., or granting access to such information by me, may cause irreparable injury to SMH or the owners of such information;
- Violations of my duty to maintain the confidentiality of all confidential information will subject me to appropriate disciplinary action according to SMH's progressive discipline policy (HR-770), up to and including dismissal, or such action allowed by law or contract.

AGREEMENT

I accordingly agree that, except as directed by Administration:

- I will not at any time during or after my service to SMH, disclose of any such services or information to any person or permit any person to examine or make copies of any reports or documents prepared by me or coming into my possession or under my control;
- I will retain all information belonging to any vendor, provider, patient or SMH in strictest confidence, and will not release such information or materials to anyone or use any such information for any purpose except to perform my duties at SMH;
- I will at all times comply with the confidentiality and information systems security policies in effect at SMH.

I have read and understand all of the above sections of this agreement.

_____ _____

Signature Date

_____

Print Name

Revised February 26 2016

VOLUNTEER AND INTERN AGREEMENT

As a Volunteer or Intern at Slidell Memorial Hospital (SMH):

- I understand that I am not entitled to and will not receive any compensation, salary, benefits or payments in exchange for my providing services to SMH.
- I understand that my service is donated without contemplation of future employment, and given with humanitarian, religious or charitable reasons.
- I understand that I am not covered by any state or federal wage and hour laws, nor am I eligible for workers' compensation, unemployment insurance benefits, or any other benefit available to employees.
- I release, discharge and relieve SMH from any and all claims whatsoever of any nature arising as a result of my services and all related activities.

Furthermore, as a Volunteer or Intern at Slidell Memorial Hospital (SMH), I agree

- to: Respect all patient or hospital related information as confidential.
- Adhere to all hospital policies, rules and standards of conduct that apply to hospital employees and independent contractors including the hospital's policy on confidentiality which I have signed and submitted.
- Report to my assignment as scheduled or notify the department supervisor.
- Avoid seeking out or visiting with friends who are patients or who are working in other departments during the hours of my assignment.
- Be neat in appearance and in uniform when on assignment, with name tag clearly visible.
- Be courteous and pleasant to patients, visitors, staff, volunteers/interns.
- Follow instructions carefully. Ask questions if unsure of an assignment.
- Uphold the good name of SMH to the community.
- Discuss any problems with the volunteer coordinator so that we can work together to solve them or understand them.
- Attend two meetings a year.
- Attend educational seminars sponsored by SMH yearly.

Revised February 26 2016

I understand that during my 60 day probationary period, I may be assigned to a Welcome/Information area for training. After that time, I will be able to move into other areas that may be open and/or seeking volunteers or interns.

I also understand that the Coordinator of Volunteer Services reserves the right to terminate my status at SMH if I fail to follow policies, rules and regulations; if I am absent without prior notice; or if I have unsatisfactory attitude or appearance. Finally, I understand that I can be terminated for giving unsatisfactory service or for any other circumstances which, in the judgment of the Coordinator of Volunteer Services, would make my continued service contrary to the best interests of Slidell Memorial Hospital.

_____ _____

Signature Date

_____

Name (Print)

LOUISIANA WORKFORCE COMMISSION

1001 North 23rd Street
Post Office Box 44187
Baton Rouge, LA 70804-4187

(O) 225-342-7866
800-201-2493
(F) 225-219-5968

Bobby Jindal, Governor
Curt Eysink, Executive Director

Office of Workers' Compensation Administration
Second Injury Board

LA OWCA Second Injury Board Knowledge Questionnaire

The following questionnaire should only be completed by individuals that have been hired for employment. Your employer may ask that you complete this questionnaire following your initial hire and periodically thereafter.

The questionnaire may be used in the establishment of prior knowledge for the purpose of obtaining Second Injury Fund relief from the Second Injury Board. The Second Injury Board may reimburse your employer for workers' compensation claims that meet certain criteria should you become injured on the job. This reimbursement in no way affects the benefits owed to you by your employer or their insurance company under the Louisiana Workers' Compensation Act, La. R.S. 23:1021-1361.

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.

Organization: Slidell Memorial Hospital, Volunteer Services

Volunteer/Intern Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number:(__) _____

Signature: _____ Date: _____

Witness: _____ Date: _____

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Please place a check in the appropriate box next to each medical condition listed below. Each illness or condition requires a Yes (Y) or No (N) answer. For all conditions that you check yes, write a brief explanation on the Explanation Page.

Disease and Other Medical Conditions [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

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

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

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 _____

Signature:_____ Date: _____

Witness:_____ Date: _____

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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: ____

Signature:____ Date: ________________________

Witness:____ Date: ________________________

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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 you currently restricted? Yes ☐ No ☐
   What is the medical condition for which you are restricted? _____

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 presently 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: _____

Signature:_____ Date: _____

Witness:_____ Date: _____

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.

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.

Signature:_____ Date: _____

Name Printed: _____

I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation Page as needed. I have confirmed the number of and labeled the pages of this questionnaire.

Witness:_____ Date: _____

Witness Printed: _____

Title: _____