

Injured Worker's Name	Claim Number	Mailing Date	<b>PAGE 1</b>
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**DIRECTIONS:** PLEASE PRINT OR TYPE USING BLACK OR BLUE INK. Read and answer each question. If additional space is needed to respond, use the back of these pages or a separate sheet of paper. Please be sure to sign and date the last page and **return this questionnaire to Workforce Safety & Insurance at the address listed above within 14 days from the mailing date listed above.** Injured workers are subject to penalty for failure to comply or for any false statement.

1. Have you ever had hearing trouble?  Yes  No  
**If yes, describe:**
  
2. Do you now have hearing trouble?  Yes  No  
**If yes, describe:**
  
3. When did you first realize you could not hear well?
  
4. Was the hearing problem of sudden or gradual onset?
  
5. Has anyone ever suggested that you have hearing trouble?  Yes  No  
**If yes, by who and when:**
  
6. Have you ever had an audiogram (hearing test) performed on you?  Yes  No  
**If yes, when and where:**
  
7. How long has it been since your most recent exposure to noise?  
  
 What was the noise from?
  
8. Do you work in a noisy area?  Yes  No
  
9. Do you wear any kind of hearing protection in your work area?  Yes  No  
**If yes, what type do you use? (i.e. muff, ear plugs)**
  
10. How long have you used this hearing protection?
  
11. Do you wear the hearing protection all the time?  Yes  No
  
12. Does your hearing improve when you are away from the job?  Yes  No  
**Overnight?**  Yes  No  
**Days off?**  Yes  No

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13. Do you have a second job?  Yes  No  
**If yes**, what and where:

Length of employment:

14. Prior to your current employment, have you ever worked in a noisy industry where you had to raise your voice?  
 Yes  No  
**If yes**, for how long?

What was the job?

Who was your employer?

When did you work for them?

15. Were you in the military service?  Yes  No  
**If yes**, give dates of service:

16. What type of gunfire were you exposed to? (artillery, small arms, other)

17. Have you been exposed to loud noises off the job? (Hunting, motorcycles, snowmobiles, hard rock music, etc.)  
 Yes  No  
**If yes**, describe:

18. Do you swim or scuba dive?  Yes  No

19. What type of shooting sports do you participate in? (Hunting, target, skeet, trap, other)

20. Have you ever been exposed to blasting or other explosive noises?  Yes  No  
**If yes**, describe:

21. Have you ever been struck on the head or neck?  Yes  No  
**If yes**, describe:

22. Have you ever suffered a head injury with unconsciousness?  Yes  No  
**If yes**, when?

Describe:

23. Have you ever had diabetes?  Yes  No  
**If yes**, how long?

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24. Have you ever suffered from periods of dizziness or loss of balance?  Yes  No  
**If yes**, when and how long did each episode last?

25. Have you ever had ear trouble as a child or adult?  Yes  No  
**If yes**, when?

26. Have you ever had ear drainage?  Yes  No  
**If yes**, when?

27. Have you ever punctured/perforated your eardrums?  Yes  No  
**If yes**, when?

28. Have you ever had ear surgery?  Yes  No  
**If yes**, why?

When?

29. Have you ever had ear or head noises?  Yes  No  
**If yes**, describe:

30. Have you ever had ear infections?  Yes  No  
**If yes**, describe:

31. Have you ever had mumps, measles, scarlet fever, or other high fevers?  Yes  No  
**If yes**, which?

When?

32. Do you have recurring headaches?  Yes  No

33. Do you have difficulty hearing at times?  Yes  No

34. Have you gone to a doctor for hearing problems?  Yes  No  
**If yes**, list dates, names, addresses of doctors, their findings, their treatments, and results of hearing test:

35. Are you presently under medical care by a doctor?  Yes  No  
**If yes**, for what condition?

Name of doctor?

36. What kind of medications do you now take (or have taken) for medical treatment?

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37. Have any members of your family ever suffered any hearing loss?  Yes  No  
**If yes, what caused the hearing loss?**

38. Do you wear a hearing aid?  Yes  No  
**If yes, how long have you had it?**

39. Does the hearing aid help your hearing ability?  Yes  No

40. Describe your hearing ability in your own words:

41. Injured worker's remarks:

**UPON COMPLETION OF THIS FORM, PLEASE SIGN, DATE, AND RETURN IT TO:**

Attn Claims Department  
 Workforce Safety & Insurance  
 PO Box 5585  
 Bismarck, ND 58506-5585

**FRAUD WARNING – PENALTY FOR FILING FALSE CLAIMS  
 WITH WORKFORCE SAFETY & INSURANCE (WSI)**

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment in connection with any claim or application for workers compensation benefits will FORFEIT ANY FUTURE BENEFITS and may be GUILTY OF A FELONY which is punishable by IMPRISONMENT, SUBSTANTIAL FINES, OR BOTH. These criminal penalties are applicable to ALL PERSONS dealing with the Fund, including INJURED WORKERS, EMPLOYERS, MEDICAL PROVIDERS, AND ATTORNEYS.

I ACKNOWLEDGE, by my signature on this form, THAT I HAVE READ AND UNDERSTAND THE ABOVE DESCRIPTION OF THE PENALTIES FOR SUBMITTING A FALSE CLAIM FOR BENEFITS OR MAKING FALSE STATEMENTS TO WSI. I understand that NDWC is relying upon the truth of my statements in awarding benefits or providing services on this claim. I CERTIFY THAT I HAVE NOT FILED A FALSE CLAIM, NOR MADE ANY FALSE STATEMENT, NOR KNOW OF ANY FALSE STATEMENT MADE IN CONNECTION WITH THIS CLAIM FOR BENEFITS WITH WSI.

Injured Worker's Signature	Date
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