



**DERMATITIS
QUESTIONNAIRE**
CLAIMS DIVISION
SFN 52959 (01/2018)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

SECTION 1 – Worker's information

Claim number	Worker's (First name)	(Last name)
Body part(s)		

SECTION 2 – Questions

Have you had dermatitis before this occurrence?
 Yes No

If yes, which body parts?

If yes, when?

If yes, list the name(s) and addresses of all medical providers who have treated you for dermatitis in the past.

Describe work-related materials handled or used.

How much time per day do you handle or use these materials?

Do you wear protective equipment?
 Yes No

If no, why not?

If yes, what type of protective equipment?

If you use chemicals at work, how do you clean your hands, arm, face etc. (Example: soap, shower, or cleaners)?

Do you use cosmetics?
 Yes No

If yes, what kind?

Do you use hand sanitizer?
 Yes No

If yes, how often?

Do you use body lotions and/or sprays?
 Yes No

If yes, how often and list the name of the product.

Do you have any pets?
 Yes No

If yes, what kind?

DERMATITIS QUESTIONNAIRE (cont'd)**SFN 52959 (01/2018)**

Claim number	Worker's (First name)	(Last name)
--------------	-----------------------	-------------

Do you have any hobbies?

 Yes No

If yes, list hobbies.

Have you eaten something recently that you normally do not eat?

 Yes No

If yes, list.

Are you on a special diet?

 Yes No

If yes, list.

List medications you take or use.

Do you have allergies?

 Yes No

If yes, list your allergies.

Have you been tested for allergies?

 Yes No

If yes, list the date(s) where the test was done, and describe the results.

Have you had or do you have skin conditions of any kind (Example: shingles, poison ivy, eczema, hives, etc.)?

 Yes No

If yes, describe.

If yes, where do you treat?

Do you have longstanding medical issues such as gastrointestinal, liver, urology, mental health conditions, or nervousness?

 Yes No

If yes, describe.

If yes, where do you treat?

SFN 52959 (01/2018)

Claim number	Worker's (First name)	(Last name)
--------------	-----------------------	-------------

SECTION 4 – Release of information/fraud warning/signature

Release of information

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records. In addition,

I authorize any educational agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S. 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations.

I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud warning

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 WSI, including injured workers, employers, medical providers, and attorneys.

Signature

By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Worker's signature

Date