CHEMICAL EXPOSURE QUESTIONNAIRE

CLAIMS DIVISION
SFN 52958 (08/2014)

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
Telephone 1-800-777-5033
Toll Free Fax 1-888-786-8695
TTY (hearing impaired) 1-800-366-6888
Fraud and Safety Hotline 1-800-243-3331
www.WorkforceSafety.com

Injured Worker's Name	Claim Number	Mailing Date	**PAGE 1**

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. What activities were you performing at the time of the exposure?

2. What was the name of the chemical you were exposed to?

3. What was the date and time of exposure?

4. Where did the exposure occur?

5. Were there any co-workers involved in the exposure? Were there any witnesses?

6. To your knowledge, has a similar incident of this type ever occurred at work previously?
   ☐ Yes ☐ No
   If yes, please answer the following:
   a. What are the circumstances surrounding that incident? What was the name of the chemical? What was the cause of the incident?

   b. Who was involved?

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Claim Number	Injured Worker

c. Was there any medical treatment provided?

d. What corrective action was taken, if any?

7. When did you start working with this chemical? What is the chemical used for in your work activities?

8. How long have you been exposed to this chemical?
   a. Hours per day?
   b. Days per week?
   c. How many years?

9. Were you wearing protective equipment at the time of the exposure? ☐ Yes ☐ No
   If no, why?

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 WSI 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