



**CHEMICAL EXPOSURE
QUESTIONNAIRE**
CLAIMS DIVISION
SFN 52958 (12/2017)

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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	
What activities were you performing at the time of the exposure?	
What is the name of the chemical you were exposed to?	What was the date of the exposure?
Where did the exposure occur?	Were there co-workers involved in the exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No
How long have you worked with this chemical?	How much time per day are you exposed to this chemical?
What is the chemical used for in your work activities?	
Were you wearing protective equipment at the time of the exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why not?	
If yes, what type of protective equipment?	
SECTION 3 – Release of information/fraud warning/signature	
<p>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.</p>	
<p>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.</p>	
<p>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.</p>	
Worker's signature	Date