DERMATITIS QUESTIONNAIRE

CLAIMS DIVISION
SFN 52959 (10/2014)

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. Have you ever had dermatitis prior to this instance? ☐ Yes ☐ No
   If yes, describe:

2. Date and time dermatitis first noticed?

3. Describe symptoms in detail including skin appearance and feeling and parts of body affected,(i.e. itching, burning, soreness) and if it is constant or intermittent.

4. What was skin condition prior to this flare-up?

5. When is problem most annoying?

6. Are there any others at work with same condition? ☐ Yes ☐ No
   If yes, whom?

7. Describe work-related materials handled and contacted and the duration of the time each was handled?

8. Are any work-related protective clothing or devices of any kind used? ☐ Yes ☐ No
   If yes, please describe:

9. Are any special provisions for cleaning up after work required, shower, soap, or cleaners?
   ☐ Yes ☐ No
   If yes, please list:

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10. Has there been any lost time from work due to this condition (include dates)?

11. Describe your personal health habits, how often do you wash or shower?

12. Do you use cosmetics? ☐ Yes ☐ No
If yes, what kind?

13. Do you use hand sanitizer? ☐ Yes ☐ No
If yes, how often?

14. Do you use scented body lotions and/or sprays? ☐ Yes ☐ No
If yes, how often and explain the type and name of product:

15. Do you have any pets? ☐ Yes ☐ No
If yes, what kind?

16. Please list any hobbies or activities you do away from work.

17. Have you eaten anything lately that you normally do not eat?

18. Are you on any special diet or diet medication? ☐ Yes ☐ No
If yes, please list

19. Are you involved with home preparation of foods, feeling of vegetables, acidic foods, canned or fermented foods?

20. Has your doctor told you that you have to much acid in your system?

21. Do you have any allergies? If so, have you had any testing done, patch or lab tests?
☐ Yes ☐ No
If yes, include results

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22. Do you have any longstanding medical problems, such as gall bladder infection, urology problems, mental problems, nervousness or use of tranquilizers? ☐ Yes ☐ No
If yes, please describe

23. Do you have any worries or tensions outside of work? ☐ Yes ☐ No
If yes, please describe

24. Please list all medication(s) you are currently taking or have taken recently

25. Have you had any previous skin conditions of any kind (such as shingles, poison ivy, poison oak, eczema, hives, etc)? ☐ Yes ☐ No
If yes, please describe

26. What has your doctor told you regarding returning to work? Please check the one that applies:
☐ still working, was not taken off work
☐ can return to work
☐ can return to work with restrictions
☐ can't return to work

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