WSI
North Dakota Workforce Safety & Insurance

DERMATITIS QUESTIONNAIRE

CLAIMS DIVISION
SFN 52959 (03/2024)

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 – *Injured employee's information*

Claim number	Injured employee'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?

C150

Claim number	Injured employee'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?
When did you become aware your condition was related to your work?

Claim number	Injured employee's (First name)	(Last name)

SECTION 3 – *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 education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g.

This authorization lasts for 1 year after the date signed unless I enter a different expiration date here _____.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

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 employees, 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.

Injured employee's signature	**Date**