



**HEARING AND NOISE  
QUESTIONNAIRE**  
CLAIMS DIVISION  
SFN 51698 (12/2020)

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

<b>SECTION 1 – Employee’s information</b>		
Claim number	Employee’s (First name)	(Last name)
Body part(s)		
<b>SECTION 2 – Current condition</b>		
When did you become aware your condition was related to your work?		
When did you first realize you could not hear well?	Have you seen a doctor for your hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list the date(s), name(s), and addresses of all medical providers who treated you.		
Have you had an audiogram (hearing test) performed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, list the date(s), name(s), and addresses of all medical providers who treated you.		
Do you have reoccurring headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list medications.		
Do you wear hearing aids? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have any of your family members suffered hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you work in a noisy area? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear any kind of hearing protection in your work area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what type do you use?		
How long have you used this hearing protection?		
Do you wear hearing protection all the time? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were you in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been exposed to gunfire, explosives, or other blasting noises (Example: artillery, small arms, other)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been exposed to loud noises outside of work (Example: hunting, motorcycles, snowmobiles, tractors, loud music, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you swim or scuba dive? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>SECTION 3 – Prior condition</b>		
Have you ever been struck in the head or neck? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe.		

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Claim number	Employee's (First name)	(Last name)
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Have you ever suffered a head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe.
Have you ever had prior ear trouble (Example: ear drainage, ear infection)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe.
Have you ever punctured/perforated your eardrums? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe.
Have you ever had inner ear surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the date(s), name(s), and addresses of all medical providers who treated you.
Have you ever had ringing in your ears? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had mumps, measles, scarlet fever, or other high fevers? <input type="checkbox"/> Yes <input type="checkbox"/> No

**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.

<b>Employee's signature</b>	<b>Date</b>
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