North Dakota Workforce Safety & Insurance

HEARING AND NOISE QUESTIONNAIRE

CLAIMS DIVISION
SFN 51698 (03/2024)

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Fraud and Safety Hotline 800-243-3331
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SECTION 1 – *Injured employee's information*

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

Body part(s)

SECTION 2 – *Current condition*

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? ☐ Yes ☐ 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?
☐ Yes ☐ No

If yes, list the date(s), name(s), and addresses of all medical providers who treated you.

Do you have reoccurring headaches? ☐ Yes ☐ No	Do you take medications? ☐ Yes ☐ No

If yes, list medications.

Do you wear hearing aids? ☐ Yes ☐ No	Have any of your family members suffered hearing loss? ☐ Yes ☐ No
Do you work in a noisy area? ☐ Yes ☐ No	Do you wear any kind of hearing protection in your work area? ☐ Yes ☐ No

If yes, what type do you use?

How long have you used this hearing protection?

Do you wear hearing protection all the time?
☐ Yes ☐ No

Were you in the military?
☐ Yes ☐ No

Have you been exposed to gunfire, explosives, or other blasting noises (Example: artillery, small arms, other)?
☐ Yes ☐ No

Have you been exposed to loud noises outside of work (Example: hunting, motorcycles, snowmobiles, tractors, loud music, etc.)?
☐ Yes ☐ No

Do you swim or scuba dive?
☐ Yes ☐ No

SECTION 3 – *Prior condition*

Have you ever been struck in the head or neck?
☐ Yes ☐ No

If yes, describe.

Have you ever suffered a head injury?
☐ Yes ☐ No

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

If yes, describe.

Have you ever had prior ear trouble (Example: ear drainage, ear infection)?
☐ Yes ☐ No

If yes, describe.

Have you ever punctured/perforated your eardrums?
☐ Yes ☐ No

If yes, describe.

Have you ever had inner ear surgery?
☐ Yes ☐ 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?
☐ Yes ☐ No

Have you ever had mumps, measles, scarlet fever, or other high fevers?
☐ Yes ☐ 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.

Injured employee's signature	**Date**