



S.C. SECOND INJURY FUND QUESTIONNAIRE

For the purposes of fulfilling the requirements of S.C. Code Ann., Section 42-9-400, your employer needs to know if, to the best of your knowledge, you have ever had any of the following conditions:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>		
(1)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	(16)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic osteomyelitis
(2)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	(17)	<input type="checkbox"/>	<input type="checkbox"/>	Ankylosis of joints
(3)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac disease	(18)	<input type="checkbox"/>	<input type="checkbox"/>	Hyperinsulinism
(4)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	(19)	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy
(5)	<input type="checkbox"/>	<input type="checkbox"/>	Amputated foot, leg, arm, or hand	(20)	<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis
(6)	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sight of one or both eyes of partial loss of uncorrected vision of more than seventy-five percent bilateral	(21)	<input type="checkbox"/>	<input type="checkbox"/>	Thrombophlebitis
(7)	<input type="checkbox"/>	<input type="checkbox"/>	Residual disability from Poliomyelitis	(22)	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
(8)	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	(23)	<input type="checkbox"/>	<input type="checkbox"/>	Heavy metal poisoning
(9)	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	(24)	<input type="checkbox"/>	<input type="checkbox"/>	Ionizing radiation injury
(10)	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	(25)	<input type="checkbox"/>	<input type="checkbox"/>	Compressed air sequelae
(11)	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral vascular accident	(26)	<input type="checkbox"/>	<input type="checkbox"/>	Ruptured disc
(12)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	(27)	<input type="checkbox"/>	<input type="checkbox"/>	Hodgkins disease
(13)	<input type="checkbox"/>	<input type="checkbox"/>	Silicosis	(28)	<input type="checkbox"/>	<input type="checkbox"/>	Brain damage
(14)	<input type="checkbox"/>	<input type="checkbox"/>	Psychoneurotic disability following treatment in a recognized medical or mental institution	(29)	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
(15)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	(30)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
				(31)	<input type="checkbox"/>	<input type="checkbox"/>	Sickle-cell anemia
				(32)	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary disease
				(33)	<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation
				(34)	<input type="checkbox"/>	<input type="checkbox"/>	Have you suffered from any other pre- existing disease, condition or impairment which is permanent in nature? (If yes, please explain on separate form).

ACKNOWLEDGEMENT AND RECORDS RELEASE

I understand this questionnaire is for the purposes of enabling my employer to fulfill the requirements of the South Carolina Second Injury Fund, and it is in no way connected to the Company's decision to hire me. The information provided is not to be used by the Company as a basis of denying me placement within the Company or promotion, or to discriminate against me in any way. The information provided is true to the best of my information and belief.

AUTHORIZATION AND RELEASE FOR VERBAL/ORAL/WRITTEN COMMUNICATION WITH MEDICAL PROVIDERS, GOVERNMENT AGENCY AND EMPLOYERS

In the event of a work related accident, my employer or its representative is authorized to have oral/verbal communication/discussion with and to request and review all medical records/documents pertaining to any of the conditions described herein as well as any records maintained by any government agency, past employer, or treatment facility with respect to any personal injuries I have received.

Signed: _____ Date: _____
Employee's Signature

Witness: _____ Date: _____
Witness' Signature