

SECOND INJURY FUND

The second injury fund is a pool of money managed by the State of Alaska to reimburse employers who qualify by reason of an employee's second injury, if the combined injuries should become severely disabling. The intent is to remove or reduce barriers to employment for disabled individuals. To qualify for reimbursement, employers must provide documentation that they had knowledge of the pre-existing disability PRIOR to the second injury occurring and that the employee was retained in employment after the employer obtained that knowledge. After hire at the University of Alaska, new employees complete a second injury fund Notice of Previous Injury or Illness questionnaire. This information is not used in the hiring decision but is maintained in a separate medical file for the employee in the event documentation is needed for a second injury fund claim to the State of Alaska. Individuals involved in the selection process should NOT present this form or ask about medical or physical impairments until after a job offer is made. Doing so before a job offer would violate the Americans with Disabilities Act (ADA).

UNIVERSITY OF ALASKA

Notice of Previous Injury and Illness

DIV/DEPT/UNIT		
Last Name	First	M.
UA Employee ID		

Information submitted herewith is intended for use by the University of Alaska for workers' compensation claims handling purposes and second injury fund documentation under the Alaska Workers' Compensation Act (AS 23.30.040 & 205). This document is to be completed post-hire and is not to be considered a condition of employment.

Have you had any previous work related injuries or illness? Yes No

If the answer is "YES", please complete the following detail: (Use Supplemental Sheet if more than one injury)

Type of injury or illness:	Date when injury or illness occurred:
Employer name and address:	
Time off for injury or illness: From: To:	Permanent disability for which benefits were paid:

Please check all of the following conditions which you have had in the past or currently have:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> epilepsy (seizures) | <input type="checkbox"/> hemophilia (bleeding disorder) |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> chronic osteomyelitis (bone infection) |
| <input type="checkbox"/> cardiac disease (heart disease) | <input type="checkbox"/> osteoporosis (brittle bones) |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> ankylosis of joints (stiff joints) |
| <input type="checkbox"/> amputated foot, leg, arm or hand | <input type="checkbox"/> hyperinsulinism (too much insulin) |
| <input type="checkbox"/> loss of sight of one or both eyes or a partial
loss of uncorrected vision of more than
75% bilaterally | <input type="checkbox"/> muscular dystrophies (muscle diseases) |
| <input type="checkbox"/> residual disability from poliomyelitis (polio) | <input type="checkbox"/> arteriosclerosis (hardening of the arteries) |
| <input type="checkbox"/> cerebral palsy | <input type="checkbox"/> silicosis (lung disease cause by silicon) |
| <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> heavy metal poisoning |
| <input type="checkbox"/> cerebral vascular accident (stroke or bleeding
in the brain) | <input type="checkbox"/> ionizing radiation injury (from x-rays or beta rays) |
| <input type="checkbox"/> tuberculosis | <input type="checkbox"/> compressed air sequelae |
| <input type="checkbox"/> thrombophlebitis (swelling of the veins,
blood clots) | <input type="checkbox"/> ruptured intervertebral disk (ruptured disk,
herniated disk, slipped disk) |
| | <input type="checkbox"/> spondylolisthesis (dislocated back) |
| | <input type="checkbox"/> NONE OF THESE CONDITIONS
APPLY TO ME. |

I Certify that all statements made on this form are true and accurate to the best of my knowledge.

Employee Signature

Date

SUPPLEMENTAL SHEET

Type of injury or illness:	Date when injury or illness occurred:
Employer name and address:	
Time off for injury or illness: From: To:	Permanent disability for which benefits were paid:

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