



MIAMI DADE COLLEGE

Worker's Compensation Questionnaire

Employee's Name:

SSN:

Do you or have you had any of the following: Check all that apply.

Hernia of Rupture

Defective Sight

Defective Hearing

Back Injury

Surgery

Diabetes

High or Low Blood Pressure

Epilepsy

Dizziness

Nerve Damage

Respiratory Disorders

Rheumatism or Arthritis

Physical Deformation or Amputations

If yes, explain:

Have you ever been hospitalized? If yes, explain:

Have you ever received psychological or psychiatric treatment?

Name of Doctor:

Have you ever made a Worker's Compensation claim for hernia, slipped disk, strain or sprain of back or shoulders?

Do you ever "blackout" temporarily while lifting?

Who is your family doctor?

Medication Allergies:

I certify that I have answered all questions to the best of my ability and understand that falsification will be considered cause for dismissal. I also understand that my employer has the right to investigate my past medical history on any previous Worker's Compensation injury claim with the industrial Commissions for the State I am working in.

Employee's Signature:

Date:

