

## E-2 PRE-EXISTING CONDITIONS

NAME: LAST	FIRST	MIDDLE	AGE	SOCIAL SECURITY NUMBER
ADDRESS: CITY	STATE	ZIP	POSITION	
<p><b>FAILURE TO RESPOND TRUTHFULLY TO THIS SECTION MAY RESULT IN THE FORFEITURE OF ANY WORKER'S COMPENSATION BENEFITS DUE TO YOU UNDER R.S. 23:1208.1 IN THE EVENT YOU SUSTAIN ANY ON THE JOB INJURY AND ILLNESS. DISCLOSURE OF A PRE-EXISTING CONDITION SHALL NOT BE A BAR TO EMPLOYMENT OR USED FOR ANY TYPE OF DISCRIMINATION.</b></p>				
<p>PLACE AN (X) NEXT TO THE CONDITION IF YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING:</p>				
___ Arthritis	___ Cerebral Palsy	___ Ruptured or Herniated Intervertebral Disc		
___ Epilepsy	___ Cardiac Disease	___ Heart Problems - Angina, Prior Heart Attack, etc.		
___ Diabetes	___ Brain Damage	___ Residual Disability from Polio		
___ Deafness	___ Varicose Veins	___ Cerebral Vascular Accident - Stroke		
___ Silicosis	___ Multiple Sclerosis	___ Arteriosclerosis - Blocked Arteries		
___ Tuberculosis	___ Loss of Vision	___ Thrombophlebitis		
___ Hodgkin's Disease	___ Amputated Limbs or Body Parts	___ Parkinson's Disease		
___ Muscular Dystrophy	___ Any Other Disabling Condition			
___ Any Prior Worker's Compensation Claims and/or Settlements				
<p>Describe pre-existing permanent disability, when and where incurred, extent of disability, etc. List name and address of employer at time of injury.</p>				
SIGNATURE OF WITNESS	SIGNATURE OF APPLICANT			DATE SIGNED