Workers Compensation

Employee Name:	Caudannia Stewart
Employer:	Southern Medical Staffing
DOB:	06/13/1987
Gender:	Female
Social Security Number:	3524
Telephone Number:	2252396647
Address:	8235 Greenwell Springs Rd. Apt. 11 Baton Rouge, La. 70814
Employee Signature:	Caudannia Stewart
Date:	12/04/2023
Employer Witness:	-
Date:	-
Disease And Other Medical Condition:	-

Surgical Treatment

Spinal Disc Surgery:	
Spinal Fusion Surgery:	
Amputated Foot:	
Amputated Leg:	
Amputated Arm:	
Amputated Hand:	
Knee Replacment:	
Hip Replacment:	
Other Joint Replacment:	No
OtherJoint:	-
Year:	-
Other Surgical Procedure:	No
Procedure:	tubaligation
Year:	2015
Employee Signature:	Caudannia Stewart
Date:	12/04/2023
Employer Witness:	-
Date:	-

Explanation Page

Condition:	-
Year Diagnosed(approx):	-
Are You Still Treating For Condition:	No
Are you taking medication for this condition?:	No
Do you have any permanent restriction for this condition?	No
Breif Explanation :	-
Condition:	-
Year Diagnosed(approx):	-
Are You Still Treating For Condition:	-
are you taking medication for this condition?:	-

Do you have any permanent restriction for this condition?	-
Breif Explanation :	-
Condition:	-
Year Diagnosed(approx):	-
Are You Still Treating For Condition:	-
Are you taking medication for this condition?:	-
Do you have any permanent restriction for this condition?	-
Breif Explanation :	-
Condition:	-
Year Diagnosed(approx):	-
Are You Still Treating For Condition:	-
are you taking medication for this condition?:	-
Do you have any permanent restriction for this condition?	-
Breif Explanation :	-
Employee Signature:	Caudannia Stewart
Date:	12/04/2023
Employer Witness:	-
Date:	-

Please answer the Following questions.

Has Any Doctor ever restricted your activities?	No
If Yes,please list the restriction:	-
Where the restiction:	Temporary
Are you currently resticted?:	No
What is the medical condition for which you are restricted:	-
Are you presently treating with a doctor, chiropractor,psychiatrist,psychologist or other health care provider?	No
Please list medical condition being treated:	-
Doctor Name:	-
Specialty:	-
Doctor's Address:	-
Medication:	-
Doctor:	-
Medication:	-
Doctor:	-
Have you ever had an on the job accident?:	Yes
if you answered yes,please provide the date for each inquiry and the nature of inquiry.:	May 2022
How Long were you on compensation:	2 mths
Name of employer:	Advantage Medical Professionals
Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee,hip or shoulder replacement?:	No

if you answered yes,please provide :

Recommended Surgery : -

Approximiate date for recommendation: -

Doctor's Name: -

Specialty: -

Doctor's Address -

Employee Signature: Caudannia Stewart

Date: 12/04/2023

Employer Witness: -

Date: -

Warning

FAILURE TO ANSWER TRUTHFULLY AND / OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S.23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in the loss of my worker's compensation benefits should I become injured on the job.

I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation page as needed. I have confirmed the number of and labeled the pages of this questionnaire.

Employee Signature: Caudannia Stewart

Date: 2023/12/04 19:41:18

Employee Printed: Caudannnia Stewart