FORM 1-A

Conditional Employee and Food Employee Interview

Preventing Transmission of Diseases through Food by Infected Food Employees or Conditional Employees with Emphasis on illness due to Norovirus, ***Salmonella*** **Typhi,** ***Shigella*** spp., Enterohemorrhagic (EHEC) or Shiga toxin-producing ***Escherichia coli*** (STEC), or hepatitis A Virus

The purpose of this interview is to inform conditional employees and food employees to advise the person in charge of past and current conditions described so that the person in charge can take appropriate steps to preclude the transmission of foodborne illness.

Conditional employee name (print) ____
Food employee name (print) ____
Address ____
Telephone *Daytime:*_____________________ *Evening:* _______________________
Date ____________________________________

Are you suffering from any of the following symptoms? (Circle one)

		If YES, Date of Onset
Diarrhea?	**YES / NO**	_________________
Vomiting?	**YES / NO**	_________________
Jaundice?	**YES / NO**	_________________
Sore throat with fever?	**YES / NO**	_________________

Or

Infected cut or wound that is open and draining, or lesions containing pus on the hand, wrist, an exposed body part, or other body part and the cut, wound, or lesion not properly covered? **YES / NO**
(Examples: *boils and infected wounds, however small)*

In the Past:

Have you ever been diagnosed as being ill with typhoid fever (*Salmonella* Typhi) **YES / NO**
If you have, what was the date of the diagnosis? ______________________
If within the past 3 months, did you take antibiotics for *S. Typhi?* **YES / NO**
If so, how many days did you take the antibiotics? ______________
If you took antibiotics, did you finish the prescription? ______________ **YES / NO**

History of Exposure:

1. Have you been suspected of causing or have you been exposed to a confirmed foodborne disease outbreak recently? **YES / NO**
If YES, date of outbreak: _____________________

a. If YES, what was the cause of the illness and did it meet the following criteria?
Cause: ____

- **i. Norovirus (last exposure within the past 48 hours)** **Date of illness outbreak** __________
- **ii. *E. coli* O157:H7 infection (last exposure within the past 3 days)** **Date of illness outbreak** __________
- **iii. Hepatitis A virus (last exposure within the past 30 days)** **Date of illness outbreak** __________
- **iv. Typhoid fever (last exposure within the past 14 days)** **Date of illness outbreak** __________
- **v. Shigellosis (last exposure within the past 3 days)** **Date of illness outbreak** __________

FORM 1-A (continued)

b. If YES, did you:

i. Consume food implicated in the outbreak? ______________________________

ii. Work in a food establishment that was the source of the outbreak? ________________

iii. Consume food at an event that was prepared by person who is ill? ________________

2. Did you attend an event or work in a setting, recently where there was a confirmed disease outbreak? **YES / NO**

If so, what was the cause of the confirmed disease outbreak? ______________________

If the cause was one of the following five pathogens, did exposure to the pathogen meet the following criteria?

a. Norovirus (last exposure within the past 48 hours) **YES / NO**

b. *E. coli* O157:H7 (or other EHEC/STEC **(last exposure within the past 3 days)** **YES / NO**

c. *Shigella* spp. (last exposure within the past 3 days) **YES / NO**

d. *S.* Typhi (last exposure within the past 14 days) **YES / NO**

e. hepatitis A virus (last exposure within the past 30 days) **YES / NO**

Do you live in the same household as a person diagnosed with Norovirus, Shigellosis, typhoid fever, hepatitis A, or illness due to *E. coli* O157:H7 or other EHEC/STEC**?**

YES / NO Date of onset of illness ______________

3. Do you have a household member attending or working in a setting where there is a confirmed disease outbreak of Norovirus, typhoid fever, Shigellosis, EHEC/STEC **infection, or hepatitis A?**

YES / NO Date of onset of illness ______________

Name, Address, and Telephone Number of your Health Practitioner or doctor:

Name ____

Address ____

Telephone – *Daytime:* ________________ *Evening:* ____________________

Signature of Conditional Employee ________________________________ **Date** ________

Signature of Food Employee ____________________________________ **Date** ________

Signature of Permit Holder or Representative _______________________ **Date** ________