

ANNEX**2****Model Forms, and Other Aids**

1. Applicant / Food Employee Interview Form
2. Applicant / Food Employee Reporting Agreement
3. Applicant / Food Employee Medical Referral

Form 1**Applicant/Food Employee Interview Form**

Preventing Transmission of Diseases through Food by Infected Food
 Employees with Emphasis on illness due to ***Salmonella Typhi*, *Shigella spp.*,
Escherichia coli O157:H7**, and Hepatitis A Virus

The purpose of this form is to ensure that Applicants to whom a conditional offer of employment has been made and Food Employees advise the Person in Charge of past and current conditions described so that Person in Charge can take appropriate steps to preclude the transmission of foodborne illness.

Applicant / Food Employee Name: (print) _____

Address: _____

Telephone: Daytime: _____ Evening: _____

TODAY:

Are you now suffering from any of the following:

1. Symptoms

Diarrhea?	YES / NO
Fever?	YES / NO
Vomiting?	YES / NO
Jaundice?	YES / NO
Sore throat with fever?	YES / NO

2. Lesions containing pus on the hand, wrist or exposed body part?

(such as boils and infected wounds, however small) **YES / NO**

PAST:

Have you ever been exposed to or suspected of causing a confirmed outbreak of typhoid fever (*Salmonella Typhi*), shigellosis (*Shigella spp.*), *Escherichia coli* O157:H7 infection (*E. coli* O157:H7), or Hepatitis A (hepatitis A virus)? **YES / NO**

If you have, what was the date of the diagnosis? _____

HIGH-RISK CONDITIONS:

1. Have you been exposed to or suspected of causing a confirmed outbreak of typhoid fever, shigellosis, *E. coli* O157:H7 infection, or hepatitis A? **YES / NO**

2. Do you live in the same household as a person diagnosed with typhoid fever, shigellosis, hepatitis A, or illness due to *E. coli* O157:H7? **YES / NO**

3. Do you have a household member attending or working in a setting where there is a confirmed outbreak of typhoid fever, shigellosis, *E. coli* O157:H7 or hepatitis A? **YES / NO**

Name, Address, and Telephone Number of your Doctor

Name _____ **Address** _____

Telephone - Daytime _____ **Evening** _____

Signature of Applicant / Food Employee _____ **Date** _____

Signature of Permit Holder's Representative _____ **Date** _____

FORM 2

Applicant/Food Employee Reporting Agreement

Preventing Transmission of Diseases through Food by Infected Food
Employees with Emphasis on illness due to ***Salmonella Typhi***, ***Shigella spp.***,
Escherichia coli O157:H7, and Hepatitis A Virus

The purpose of this agreement is to ensure that Food Employees notify the Person in Charge when they experience any of the conditions listed so that the Person in Charge can take appropriate steps to preclude the transmission of foodborne illness.

I AGREE TO REPORT TO THE PERSON IN CHARGE:

FUTURE SYMPTOMS and PUSTULAR LESIONS:

1. **Diarrhea**
2. **Fever**
3. **Vomiting**
4. **Jaundice**
5. **Sore throat with fever**
6. **Lesions containing pus on the hand, wrist, or an exposed body part**
(such as boils and infected wounds, however small)

FUTURE MEDICAL DIAGNOSIS:

Whenever diagnosed as being ill with typhoid fever (*Salmonella Typhi*), shigellosis (*Shigella spp.*), *Escherichia coli O157:H7* infection (*E. coli O157:H7*), or Hepatitis A (hepatitis A virus)

FUTURE HIGH-RISK CONDITIONS:

1. Exposure to or suspicion of causing any confirmed outbreak of typhoid fever, shigellosis, *E. coli O157:H7* infection, or hepatitis A
2. A household member diagnosed with typhoid fever, shigellosis, illness due to *E. coli O157:H7*, or hepatitis A
3. A household member attending or working in a setting experiencing a confirmed outbreak of typhoid fever, shigellosis, *E. coli O157:H7* infection, or hepatitis A

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the **District of Columbia Food Code Regulations** and this agreement to comply with:

1. Reporting requirements specified above involving symptoms, diagnoses, and high-risk conditions specified;
2. Work restrictions or exclusions that are imposed upon me; and
3. Good hygienic practices.

I understand that failure to comply with the terms of this agreement could lead to action by the food establishment or the District of Columbia Department of Health that may jeopardize my employment and may involve legal action against me.

Applicant / Food Employee Name (please print) _____

Signature of Applicant / Food Employee _____ **Date** _____

Signature of Permit Holder's Representative _____ **Date** _____

FORM 3**Applicant/ Food Employee Medical Referral**

Preventing Transmission of Diseases through Food by Infected Food
 Employees with Emphasis on illness due to ***Salmonella Typhi*, *Shigella spp.*,
Escherichia coli O157:H7, and Hepatitis A Virus**

The District of Columbia Food Code Regulations, Title 25 DCMR Chapter 3, Food Employee / Applicant Health – Disease or Medical Condition, specifies that Applicants to whom a conditional offer of employment has been made and Food Employees obtain medical clearance from a physician licensed to practice medicine whenever the individual:

1. Is chronically suffering from a symptom such as **diarrhea**; or
2. Meets one of the high-risk conditions specified under Subsection 300.6 and is suffering from any symptom specified under Subsection 300.4; or
3. Has a **current illness** involving ***Salmonella Typhi*** (typhoid fever), ***Shigella* spp.** (shigellosis), ***Escherichia coli* O157:H7** (***E. coli* O157:H7** infection), or hepatitis A virus (hepatitis A); or
4. Reports **past illness** involving ***S. Typhi*** (typhoid fever), ***Shigella* spp.** (shigellosis), ***E. coli* O157:H7**, or hepatitis A virus (hepatitis A), if the establishment is a facility serving a highly susceptible population such as preschool age children, immunocompromised persons, or older adults.

Applicant / Food Employee being referred: (_____ (Name, please print) _____)

Serving a highly susceptible population ? YES NO

REASON FOR MEDICAL REFERRAL: The reason for this referral is checked below:

- Chronic diarrhea or other chronic symptom _____ (specify) _____ .
- Meets a high-risk condition specified under Subsection 300.6 _____ (specify) _____ and suffers from a symptom specified under Subsection 300.4 _____ (specify) _____ .
- Diagnosed or suspected typhoid fever, shigellosis, ***E. coli* O157:H7** infection, or hepatitis A.
- Reported past illness from typhoid fever, shigellosis, ***E. coli* O157:H7** infection, or hepatitis A.
- Other medical condition of concern per the following description: _____

PHYSICIAN'S CONCLUSION:

- Applicant or food employee is free of ***S. Typhi*, *Shigella* spp., *E. coli* O157:H7, or hepatitis A virus** and may work as a food employee without restrictions.
- Applicant or food employee is an asymptomatic shedder of ____ (pathogen) ____ and is restricted from working with exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles in establishments that do not serve highly susceptible populations.
- Applicant or food employee is not ill but continues as an asymptomatic shedder of ____ (pathogen) ____ and should be excluded from working with exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles in food establishments that serve highly susceptible populations such as those who are preschool age, immunocompromised, or older adults and in a facility that provides preschool custodial care, health care, or assisted living.
- Applicant or food employee is suffering from typhoid fever, Shigellosis, ***E. coli* O157:H7** infection, or hepatitis A and should be excluded from working with exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.

COMMENTS: In accordance with Title I of the Americans with Disabilities Act (ADA) and to provide only the information necessary to assist the food establishment operator in preventing foodborne disease transmission, please confine comments to explaining your conclusion and estimating when the employee may be reinstated.

Signature of Physician _____ Date _____

**Applicant/ Food Employee Medical Referral
Paraphrased from the FDA Food Code for Physician's Reference**

From 25 DCMR §300.3 Organisms of Concern:

Any foodborne pathogen, with special emphasis on these 4 organisms:

***S. Typhi* *Shigella* spp. *E. coli* O157:H7 Hepatitis A virus**

From 25 DCMR §300.4 Symptoms:

Symptoms associated with an acute gastrointestinal illness such as:

Diarrhea Fever Vomiting Jaundice Sore throat with fever

From 25 DCMR §300.6 High-Risk Conditions Related to a Person's Activities:

- (1) Suspected of causing a foodborne outbreak or being exposed to an outbreak caused by 1 of the 4 organisms above, at an event such as a family meal, church supper, or festival because the person:
 - Prepared or consumed an implicated food; or
 - Consumed food prepared by a person who is infected or ill with the organism that caused the outbreak or who is suspected of being a carrier;
- (2) Lives with a person who is diagnosed with illness caused by 1 of the 4 organisms; or
- (3) Lives with a person who works where there is an outbreak caused by 1 of the 4 organisms.

From 25 DCMR §301 Exclusion and Restriction:

Decisions to exclude or restrict a food employee are made considering the available evidence about the person's role in actual or potential foodborne illness transmission. Evidence includes:

Symptoms Diagnosis High-risk conditions Past illnesses Stool/blood tests

- In facilities serving highly susceptible populations such as day care centers and health care facilities, a person for whom there is evidence of foodborne illness is almost always excluded from the food establishment.
- In other establishments that offer food to typically healthy consumers, a person might only be restricted from certain duties, based on the evidence of foodborne illness.
- Exclusion from any food establishment is required when the person is:
 - Diagnosed with illness caused by 1 of the 4 organisms of concern; or
 - Jaundiced within the last 7 days.

From 25 DCMR §4503 Release of Employee from Exclusion or Restriction:

- For infection with ***S. Typhi***, the person's stools must be negative for 3 consecutive cultures taken at least 1 month after onset, no earlier than 48 hours after antibiotics are discontinued, and at least 24 hours apart.
- For ***Shigella* spp.** or ***E. coli* O157:H7** infections, the person's stools must be negative for 2 consecutive cultures taken no earlier than 48 hours after antibiotics are discontinued and at least 24 hours apart.
- For hepatitis A virus infection, the symptoms must cease or at least 2 blood tests must show falling liver enzymes.