FORM 1-C

Conditional Employee or Food Employee Medical Referral

Preventing Transmission of Diseases through Food by Infected Food Employees with Emphasis on Illness due to Norovirus, Typhoid fever (***Salmonella* Typhi**), **Shigellosis (*Shigella* spp.), *Escherichia coli* O157:H7** or other Enterohemorrhagic (EHEC) or Shiga toxin-producing ***Escherichia* coli** (STEC), and hepatitis A Virus

The **Food Code** specifies, under ***Part 2-2 Employee Health Subpart 2-201 Disease or Medical Condition***, that Conditional Employees and Food Employees obtain medical clearance from a health practitioner licensed to practice medicine, unless the Food Employees have complied with the provisions specified as an alternative to providing medical documentation, whenever the individual:

1. Is chronically suffering from a symptom such as **diarrhea;** *or*
2. Has a **current illness** involving Norovirus, typhoid fever **(*Salmonella* Typhi)**, shigellosis **(*Shigella* spp.)** ***E. coli* O157:H7** infection (or other EHEC/STEC), or hepatitis A virus (hepatitis A), *or*
3. Reports ***past illness*** involving typhoid fever **(*S.* Typhi)** within the past three months (while salmonellosis is fairly common in U.S., typhoid fever, caused by infection with ***S.* Typhi**, is rare).

Conditional employee being referred: (Name, please print) _____

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

4. Is the employee assigned to a food establishment that serves a population that meets the Food Code definition of a **highly susceptible population** such as a day care center with preschool age children, a hospital kitchen with immunocompromised persons, or an assisted living facility or nursing home with older adults?
YES ☐ **NO** ☐

Reason for Medical Referral: The reason for this referral is checked below:

☐ Is chronically suffering from vomiting or diarrhea; or (specify) _____
☐ Diagnosed or suspected Norovirus, typhoid fever, shigellosis, ***E. coli*** O157:H7 (or other EHEC/STEC) infection, or hepatitis A. (Specify) _____
☐ Reported past illness from typhoid fever within the past 3 months. (Date of illness) _____
☐ Other medical condition of concern per the following description: _____

Health Practitioner's Conclusion: (Circle the appropriate one; refer to reverse side of form)

☐ Food employee is free of **Norovirus** infection, typhoid fever **(*S.* Typhi** infection**), *Shigella*** spp. infection, ***E. coli*** O157:H7 (or other **EHEC/STEC** infection), or **hepatitis A** virus infection, and may work as a food employee without restrictions.
☐ Food employee is an asymptomatic shedder of ***E.*** coli O157:H7 (or other **EHEC/STEC**), ***Shigella*** spp., or Norovirus, and is restricted from working with exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles in food establishments that do not serve highly susceptible populations.
☐ Food employee is not ill but continues as an asymptomatic shedder of ***E. coli*** O157:H7 (or other **EHEC/STEC**), ***Shigella*** spp. and should be excluded from 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.
☐ Food employee is an asymptomatic shedder of **hepatitis A** virus and should be excluded from working in a food establishment until medically cleared.
☐ Food employee is an asymptomatic shedder of **Norovirus** and should be excluded from working in a food establishment until medically cleared, or for at least 24 hours from the date of the diagnosis.
☐ Food employee is suffering from Norovirus, typhoid fever, shigellosis, ***E. coli*** O157:H7 (or other **EHEC/STEC** infection), or **hepatitis A** and should be excluded from working in a food establishment.

FORM 1-C (continued)

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.)

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Signature of Health Practitioner _____ **Date** _____