ROGER WILLIAMS UNIVERSITY
DINING SERVICES
FOOD EMPLOYEE REPORTING AGREEMENT

PURPOSE

This agreement ensures that Roger Williams University Food Service Employees notify the Person in Charge when they experience any of the conditions listed below so that the Person in Charge can take appropriate steps to preclude the transmission of food borne illness. This agreement is being distributed upon recommendation of the State of Rhode Island Health Department.

1. FUTURE SYMPTOMS AND PUSTULAR LESIONS AS FOLLOWS:

- g Diarrhea
- g Fever
- g Vomiting
- g Jaundice
- g Sore throat with fever
- g Lesions containing pus on the hand, wrist or an exposed body part (such as boils and infected wounds, however small)

2. 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).

3. FUTURE HIGH-RISK CONDITIONS AS FOLLOWS:

- g Exposure to or suspicion of causing any confirmed outbreak of typhoid fever, shigellosis, E. coli 0157:H7 infection or hepatitis A.
- g A household member diagnosed with typhoid fever, shigellosis, illness due to E. coli 0157:H7 or hepatitis A.
- g 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.
- g Travel outside the United States within the last 50 days.

EMPLOYEE CERTIFICATION

I have read (or had explained to me) and understand the requirements concerning my responsibilities under the Food Code 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 may necessitate action by Roger Williams University or the food regulatory authority which may jeopardize my employment and may involve legal action against me.

_____
Employee Name (Print)

_____ _____/_____/_____
Signature of Employee Date

_____ _____/_____/_____
Dining Service Supervisor Date

Original - Human Resources Copy - Dining Service

3/99
I:forms.dshealth.wpd