

EMPLOYEE HEALTH QUESTIONNAIRE

Please complete the following questions. Your answers are confidential.

Name: Telephone #:

Address:

Name & address of doctor:

.....

Have you ever had, or been a carrier, of:

A Foodborne Illness	Yes	No
Typhoid	Yes	No
Hepatitis A	Yes	No
Parasitic Infections	Yes	No
Have any close family members had any of the above?	Yes	No

If so, list here:

Have you suffered from any of the following:

Serious diarrhea or vomiting	Yes	No
Skin trouble	Yes	No
Boils, or septic fingers	Yes	No
Discharge from ears, eyes, gums/mouth	Yes	No

If you answered yes to any of the above, please provide details of dates and if the doctor was contacted:

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Have you traveled outside the country within the last 2 years? Yes No

Did you ever become ill while abroad? Yes No

Where and when:

.....

If asked, will you agree to provide specimens that may be required by the Company to ensure that you are not a carrier of any illness that may infect food? Yes No

I declare that the above statements are correct and complete to the best of my knowledge. A deliberate failure to provide accurate and truthful answers may be considered as grounds for dismissal.

Sign: _____ **Date:** _____