**FACILITY NAME ▪ FACILITY LOCATION**

**Employee Interview Form**

The Minnesota Department of Health (MDH) and LOCAL PUBLIC HEALTH are working on a foodborne illness outbreak investigationthat may be associated with the facility where you work. The purpose of the investigation is to learn the source of the outbreak and stop transmission. We want to ask you questions about your work duties in food service and any recent illness you may have had.

**PRIVACY:** Any information you give to us about yourself (including test results) is considered private data. Only public health officials involved in this outbreak investigation will have access to the private data. Do we have your permission to also share this information with management staff at the facility where you work? 🞎 **YES** 🞎 **NO**

**VOLUNTARY:** You are not required to answer questions. However, your answers help us understand how this outbreak happened and prevent further transmission. If you don’t answer questions, you will be excluded from work because we won’t know if you could spread illness to others.

Will you answer some brief questions? 🞎 **YES** 🞎 **NO (exclusions apply – contact epi)**

**STOOL SAMPLE: We will be testing stool samples to see if employees have *Salmonella* (a germ that can be spread by food). You must submit two stool samples, collected at least 24 hours apart. If you have been ill, or test positive for *Salmonella*, you will be excluded from work until two stool samples in a row test negative for *Salmonella.* If you don’t submit stool specimens, you will be excluded from work because we won’t know if you could spread illness to others.** Stool kits and testing are free of charge.You will be given results when they are available.

Will you submit stool samples? 🞎 **YES** 🞎 **NO (exclusions apply – contact epi)**

**Name (last, first):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Male Female Other**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or **Phone Interview (verbal consent):** 🞎

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Job Title/Description:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you had any of the following symptoms since **September 1?**

|  |  |  |
| --- | --- | --- |
| Nausea | 🞎Y 🞎N |  |
| Vomiting | 🞎Y 🞎N | Onset date/time: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_ | Recovery: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_ |
| Cramps | 🞎Y 🞎N |  |
| Diarrhea | 🞎Y 🞎N | Onset date/time: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_ | Recovery: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_ |
|  # stools/24 hrs | \_\_\_\_\_\_ | Duration of diarrhea: \_\_\_\_\_\_ days/hours *(if unsure of dates/times)* |
| Bloody stools | 🞎Y 🞎N |  |
| Fever | 🞎Y 🞎N | Temperature: \_\_\_\_\_\_\_\_ ° F |
| First symptom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Onset date/time: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_ |  |
| Other symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When did you feel completed recovered? \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_\_ | *or*  🞎 still feeling sick |

**ILL EMPLOYEES**

|  |  |
| --- | --- |
| * Did you visit a health care provider for the illness?🞎 **YES** 🞎 **NO**
 | Hospitalized overnight? 🞎 **YES** 🞎 **NO**  |
| If yes, when? \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Submit a stool sample? 🞎 **YES** 🞎 **NO** |

* Did you work while having diarrhea and/or vomiting? 🞎 **YES** 🞎 **NO**

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If no, when did you return to work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL EMPLOYEES**

* Do you work at any other food service facilities? 🞎 **YES** 🞎 **NO**

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have any members of your household been ill with the following symptoms since **September 1**?🞎 **YES** 🞎 **NO**

Vomiting (onset: \_\_\_\_ /\_\_\_\_ ) 🞎Y 🞎N Cramps 🞎Y 🞎N Fever 🞎Y 🞎N Blood in stool 🞎Y 🞎N

Diarrhea (onset: \_\_\_\_ /\_\_\_\_ ) 🞎Y 🞎N (# stools/24 hrs: \_\_\_\_)

* Have any of your co-workers been ill with vomiting and/or diarrhea?🞎 **YES** 🞎 **NO**

Describe (who, when): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**During September 9-25:**

* Which of these dates did you work?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY |
|  | 9 |  | 10 |  | 11 |  | 12 |  | 13 |  | 14 |  | 15 |
| 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N |
|  | 16 |  | 17 |  | 18 |  | 19 |  | 20 |  | 21 |  | 22 |
| 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N |
|  |  |  |  |  |  |  |
|  | 23 |  | 24 |  | 25 |  | 26 |  | 27 |  | 28 |  | 29 |
| 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N | 🞎Y 🞎N |
|  |  |  |  |  |  |  |

**During September 9-25:**

* Did you do any food prep?🞎 **YES** 🞎 **NO**

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Did you make or serve any drinks, including adding garnish or ice?🞎 **YES** 🞎 **NO**

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Did you prepare any ready-to-eat foods, like salads, breads, or chips (including garnishing plates and packaging to-go food)?🞎 **YES** 🞎 **NO**

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* What were your other job duties?

Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_