

DNA CHILD NUTRITION EMPLOYEE HEALTH POLICY

AGREEMENT

I understand that I must:

1. Report when I have or have been exposed to any of the symptoms or illnesses listed above; and
2. Comply with work exclusions that are given to me.

I understand that if I do not comply with this agreement, it may put my job at risk.

I have fully read, understood and agree with the terms of this policy:

CNS Employee Name (please print)

Signature of CNS

Employee _____ Date _____

Manager (Person-in-Charge) Name (please print)

Signature of Manager (Person-in-

Charge _____ Date _____