Volunteer Medical Release

Please have your primary care physician complete this form. This document is strictly confidential.

Please print.

Volunteer Applicant Name ______________________ Date of Birth ______________________

Volunteer's Phone Number ______________________

Do you know of any physical, emotional or mental limitations that would interfere with the applicant's ability to function in a hospital atmosphere? ☐ Yes ☐ No

If yes, please elaborate: ______________________

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If the applicant is born after 1957, are DPT, MMR and Chicken Pox immunizations up to date?
PLEASE ATTACH PROOF (RECORD OR TITER TEST) ☐ Yes ☐ No

Additional Comments: ______________________

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Printed Physician Name ______________________

Physician Signature ______________________ Date ______________________

Office Address ______________________ City ______________________

Office Phone Number ______________________