Wellstar

AFFILIATED WITH MEDICAL COLLEGE OF GEORGIA

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: _____

_____

_____

_____

Are the applicant's DPT, MMR, and Chicken Pox immunizations up to date?

PLEASE ATTACH PROOF (RECORD OR TITER TEST) ☐ Yes ☐ No

Additional Comments: _____

_____

Printed Physician Name _____

Physician Signature _____ Date _____

Office Address _____ City _____

Office Phone Number _____

Please fax or email completed form to Wellstar MCG Health Volunteer Services at 706-721-5196 or wmcg_wellstarvolunteers@wellstar.org