



Volunteer Medical Release Form

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

Please print.

Volunteer Applicant Name _____ Date of Birth _____

Volunteer 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: _____

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: _____

Printed Physician Name _____

Physician Signature _____ Date _____

Office Address _____ City _____

Office Phone Number _____