Palisades MEDICAL CENTER
Hackensack University Health Network

VOLUNTEER SERVICES DEPARTMENT
PHYSICIAN'S CONSENT FORM

Dear Dr. _____:

_____ is interested in becoming a volunteer at Palisades Medical Center.

Are there any limitations (physical or mental) that would prohibit this service?
Yes_____ No_____ if yes, please explain limitations.

_____

_____

_____

DOCTOR PLEASE DOCUMENT HISTORY OF DISEASE OR VACCINES RECEIVED if patient was born in 1957 or later.

Immunizations:

Mumps_____
Measles (Rubeola) _____
German Measles (Rubella) _____
Chickenpox (Varicella) _____

_____
Physician's Signature (Please attach Professional Card or Stamp)

Please return to:
Palisades Medical Center
Coordinator of Volunteer Services
7600 River Road
North Bergen, NJ 07047

Sincerely,

Denise Whitley
Coordinator Volunteer Services

I have given permission for the release of the information requested.

_____
Volunteer's Signature