



**VOLUNTEER SERVICE MEDICAL FORM**

NAME:  MR.  MRS.  MS.  MISS  DR. (FIRST) \_\_\_\_\_ (LAST) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (CELL) \_\_\_\_\_

THE PERSON LISTED ABOVE HAS APPLIED FOR A VOLUNTEER POSITION AT CHAI LIFELINE. S/HE MAY WORK IN A HOSPITAL ENVIRONMENT AND/OR COME INTO CONTACT WITH IMMUNOSUPPRESSED CHILDREN OR ADULTS. YOUR RESPONSES WILL HELP US MOST APPROPRIATELY PLACE THE VOLUNTEER.

1) PPD TEST WITHIN A YEAR:  YES  NO DATE: \_\_\_\_\_ RESULTS: \_\_\_\_\_

A) IF PPD POSITIVE, CHEST X-RAY:  YES  NO DATE: \_\_\_\_\_ RESULTS: \_\_\_\_\_

B) IF INDICATED, INH THERAPY:  YES  NO DATE: \_\_\_\_\_ RESULTS: \_\_\_\_\_

2) PLEASE ATTACH TITER RESULTS FOR ALL:  MEASLES  RUBELLA  VARICELLA

3) HAS THE APPLICANT HAD A TETANUS-DIPHTHERIA VACCINATION WITHIN LAST 10 YEARS:  YES  NO DATE: \_\_\_\_\_

4) HEPATITIS B VACCINATION SERIES (OPTIONAL):

DATE OF SERIES: HBV #1: \_\_\_\_\_ HBV #2 \_\_\_\_\_ HBV #3: \_\_\_\_\_

5) DOES THE APPLICANT HAVE ANY PHYSICAL OR MEDICAL ILLNESSES THAT MIGHT INFLUENCE VOLUNTEER PLACEMENT?

YES  NO IF YES, DESCRIBE: \_\_\_\_\_

6) DOES THE APPLICANT HAVE ANY PSYCHIATRIC DISABILITY THAT MIGHT INFLUENCE VOLUNTEER PLACEMENT?

YES  NO IF YES, DESCRIBE: \_\_\_\_\_

7) ARE THERE ANY LIMITATIONS FOR VOLUNTEER PLACEMENT IN A HOSPITAL SETTING?

YES  NO IF YES, DESCRIBE: \_\_\_\_\_

COMPLETED BY (PLEASE PRINT): \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE AND TITLE OF AUTHORIZED PRACTITIONER:

\_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX \_\_\_\_\_