



**Chai Lifeline**  
Fighting Illness With Love

151 WEST 30<sup>TH</sup> STREET, NEW YORK NY 10001  
212.699.6654 • 888.244.7478 • FAX 212.465.0949  
WWW.CHAILIFELINE.ORG

DATE COMPLETED _____
DATE RECEIVED _____
REVIEWED BY _____
STATUS _____

## Volunteer Service Medical Form

NAME: Mr. Mrs. Ms. Miss Dr. (First) \_\_\_\_\_ (Last) \_\_\_\_\_

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

TELEPHONE: (H) \_\_\_\_\_ (B) \_\_\_\_\_

The above indicated individual is applying for a volunteer opportunity at Chai Lifeline. He/She may be in contact with immunosuppressed children and adults. Also, he/she may have a hospital-based assignment. Your completion of all questions will be helpful in our placement. (\*mandatory)

\*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) PLEASE INDICATE, 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) TO THE BEST OF YOUR KNOWLEDGE, DOES THE APPLICANT HAVE ANY PHYSICAL OR MEDICAL ILLNESS WHICH MIGHT INFLUENCE VOLUNTEER PLACEMENT?    YES    NO

IF YES, DESCRIBE: \_\_\_\_\_

6) TO THE BEST OF YOUR KNOWLEDGE, DOES THE APPLICANT HAVE ANY PSYCHIATRIC DISABILITY WHICH 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: \_\_\_\_\_

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

\*SIGNATURE & TITLE OF AUTHORIZED PRACTITIONER:

\_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

PLEASE RETURN TO VOLUNTEER