

PHYSICIAN FORM:

Please have your physician complete this form and upload it to your application during the 'Documents' upload portion of the digital application process.

Dear Physician:

The individual listed below has applied to become a volunteer at Premier Health. The volunteer (or his/her parent) has signed below, granting permission for you to release medical information to the volunteer office.

Many of our volunteers work in direct contact with our patients or their families and perform a variety of tasks without constant supervision. We would appreciate your frank appraisal of this candidate. This procedure was designed to safeguard the patients and to protect the hospital from damaging incidents, as well as to protect a person who is interested in volunteering but may not be able to physically or mentally perform the required tasks.

You may indicate blanket approval for any type of service, or you may impose some restrictions such as no lifting; no pushing wheelchairs or heavy carts; or no patient contact because of a physical or emotional problem. ***Please use the section below to list restrictions and for any comments.***

We appreciate your prompt response to help us place this volunteer in the appropriate position within the hospital.

Volunteer Services Office

I give permission to my physician to release relevant medical information:

Volunteer's Signature: _____

If volunteer under age 18, Parent's Signature _____

Please attach immunization documentation for MMR (Measles, Mumps, Rubella).

NOTE: Not required if born prior to 1957

Physician comments, please list any restrictions or recommendations:

Physician's Name/Office: _____ Date: _____

Physician's Signature: _____