Wyckoff Heights Medical Center
Department of Volunteer Services
374 Stockholm Street
Brooklyn, NY 11237

# PRIVATE PHYSICIAN MEDICAL RELEASE FORM

I authorize the release of the following medical information to the Department of Volunteer Services of Wyckoff Heights Medical Center.

_____ _____ _____
Volunteer's Name Date Volunteer's Signature

## MEDICAL INFORMATION

**PPD Test #1:** (Accepted only if administered less than 1 year ago)
Date planted _____ Date read _____ Results _____

If PPD positive: Please attach a copy of the most recent chest x-ray report
Date of most recent x-ray report _____ Results _____

**Rubella Titer:** Level _____ Date _____ Immune? Yes No
If no, Rubella Immunization: Date administered _____

**Rubeola Titer:** Level _____ Date _____ Immune? Yes No
If no, Rubeola Immunization: Date administered _____

**Varicella Titer:** Level _____ Date _____ Immune? Yes No
If no, Varicella Immunization: Date administered _____

**Mumps Titer:** Level _____ Date _____ Immune? Yes No
If no, Mumps Immunization: Date administered _____

**Hepatitis B Titer:** Level _____ Date _____ Immune? Yes No
If no, Hepatitis B Immunization: Date administered _____

To the best of your knowledge, does this applicant have any physical or emotional disabilities we should consider prior to placement? [ ] Yes [ ] No

If yes, please explain: _____

**In compliance with the NYS Health Code, I examined the applicant and found him/her to be free of any health impairments that would pose a potential risk to patients and hospital personnel or which may interfere with his/her responsibilities as a volunteer.**

_____ _____
Physician's Name

_____ _____ _____
Physician's Signature Date Physician's address & telephone