Wellstar
HEALTH SYSTEM

Volunteer Medical Release

Please have your primary care physician complete this form. This document is strictly confidential.

Please print.

Volunteer Applicant Name   Date of Birth

Volunteer's Phone Number

Do you know of any physical, emotional or mental limitations that would interfere with the applicant's ability to function in a hospital atmosphere? ☐ Yes ☐ No

If yes, please elaborate: ____________________

If the applicant is born after 1957, are DPT, MMR and Chicken Pox immunizations up to date?

PLEASE ATTACH PROOF (RECORD OR TITER TEST) ☐ Yes ☐ No

Additional Comments: ____________________

Printed Physician Name

Physician Signature   Date

Office Address   City

Office Phone Number

Please return to:

Department of Volunteer Services, 3000 Hospital Blvd., Roswell, GA 30076
Email: NFHVolunteers@Wellstar.org
Fax: 470-986-7080