



Palisades Medical Center

New York Presbyterian Healthcare System

VOLUNTEER SERVICES DEPARTMENT PHYSICIAN'S CONSENT FORM

Dear Dr. _____:

_____ is interested in becoming a volunteer at Palisades Medical Center.

Are there any limitations (physical or mental) that would prohibit this service?
Yes _____ No _____ if yes, please explain limitations.

DOCTOR PLEASE DOCUMENT HISTORY OF DISEASE OR VACCINES RECEIVED if patient was born in 1957 or later.

Immunizations:

Mumps _____
Measles (Rubeola) _____
German Measles (Rubella) _____
Chickenpox (Varicella) _____

Physician's Signature (Please attach Professional Card or Stamp)

Please return to:
Palisades Medical Center
Coordinator of Volunteer Services
7600 River Road
North Bergen, NJ 07047

Sincerely,

Denise Whitley
Coordinator Volunteer Services

I have given permission for the release of the information requested.

Volunteer's Signature